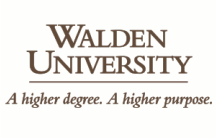

2019

Attitudes and Perceptions Among African Americans About Dating Individuals with Bipolar Disorder

Casey Michelle Johnson
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Casey M. Johnson

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Tracey Phillips, Committee Chairperson, Human Services Faculty
Dr. Eric Youn, Committee Member, Human Services Faculty
Dr. Garth den Heyer, University Reviewer, Human Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

Attitudes and Perceptions Among African Americans About Dating Individuals with Bipolar Disorder

by

Casey M. Johnson

MS, Virginia Polytechnic Institute and State University, 2009

BA, Hampton University, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Individuals who experience bipolar disorder may have difficulty acquiring and maintaining relationships due to the stigma associated with mental illness. The purpose of this generic qualitative study was to examine the attitudes and perceptions of African American men and women regarding their experiences of dating and relationships with individuals who suffer from bipolar disorder. The theory used in this study was equity theory. The research question for this study explored how African American adults experience relationship acquisition and maintenance with a partner who has been diagnosed with bipolar disorder. For this generic qualitative study, there were 12 respondents. Participants were African American adults who had dated or been in a relationship with an individual diagnosed with bipolar disorder. Themes that emerged from this study were sense of relief, sense of fear, unmodified affection, benefits of the relationship, resolution of unfair situations, reluctance to participate in a relationship with an individual diagnosed with bipolar disorder again, and race intensified the relationship. The participants associated acquisition, or the early stages of the relationship, with challenges, especially if they were unaware of the diagnosis in the beginning and could not explain certain behaviors. The results of this study can be used to promote understanding about bipolar disorder and the impact of mental illness on relationships.

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Dedication

I would like to dedicate my dissertation to all of my family members who have passed. You may not have lived to see me finish school, but I know you were my angels guiding me along the way. I love and miss you and may this accomplishment contribute to the legacy of our family.

Acknowledgments

I would like to thank the faculty who guided me through the dissertation journey. Dr. Phillips and Dr. Youn, I appreciate your caliber throughout this process. I would also like to thank my family, my mom, my dad, and my brother, as well all of my extended family who kept me in their prayers the whole way through. All of you helped me to reach this point in your academic career and I am forever grateful.

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Chapter 1: Introduction to the Study

Introduction

The purpose of this study was to examine the attitudes and perceptions of African Americans regarding dating and relationships with individuals experiencing bipolar disorder. There was an existing gap in the literature regarding African Americans, relationships, and bipolar disorder. This study has many potential social implications. Not only will the current research serve to fill a gap in the existing literature, but it will also illuminate the issue and the impact of bipolar disorder on relationships within African American culture.

In Chapter 1 of the study, I will discuss the background and scope of the study. I will then describe the social problem and purpose of the study. I will also introduce the research question along with details about the nature of the study.

Background

In this study, I addressed the attitudes and perceptions among African Americans regarding dating and relationship acquisition and maintenance with individuals experiencing mental illness, particularly bipolar disorder. The scope of this study included African Americans and relationships and African Americans and mental health with an emphasis on bipolar disorder. This study contributes to the field of mental health and promotes an understanding of relationships, as well as mental health on relationships, in an underserved community. To promote the management of mental illness such as bipolar disorder, services for persons with mental illness and serious mental illness should be developed in accordance with the patients' most prominent needs (Werner,

2012). Social and personal needs are salient regarding intimate and sexual relationships (Werner, 2012). Researchers have explored how a range of serious relationships contribute to physical, emotional, and mental health; however, there is instability in both the presence and quality of serious relationships when transitioning to adulthood (Barr, Culatta, & Simons, 2013l Werner, 2012). Particular patterns of instability are associated with changes in mental and physical health (Barr et al., 2013). Poor relationship quality in marriage and other intimate relationships are associated with a variety of mental health disorders (Whisman, Johnson, Li, & Robustelli, 2014). The prevalence of mood, anxiety, and substance use disorders was significantly correlated with negative relationship quality in a serious relationship, cohabitation, or marriage (Whisman et al., 2014). Higher levels of negative relationship quality have been correlated with the prevalence of several common psychiatric disorders and being in an intimate relationship (Whisman et al., 2014).

Race and Barriers to Mental Health Care

Racial-ethnic disparities exist in both access to and quality of mental health care services for African Americans (Johnson, Mills, DeLeon, Hartzema, & Haddad, 2009). Current mental health evaluation and treatment paradigms are not responsive to the needs of many African Americans (Johnson et al., 2009). Fear of confiding in others about mental illness, fear of social stigma, and lack of information about mental illness are barriers to mental health care and treatment response for African Americans (Johnson et al., 2009). Within the social networks of African Americans, stigmatizing attitudes toward mental illness and individuals with a mental illness, discouragement

about psychiatric medication use, and perceptions that symptoms are the result of personal or spiritual weakness all interfere with treatment seeking efforts and contribute to a common experience of social isolation (Johnson et al., 2009). Black, Curran, and Dyer (2013) identified shame as a predictor of therapeutic alliance and romantic relationship functioning in individuals with psychiatric conditions. Black et al presented mental health status as well as the potential for internalizing shame coping styles as barriers to successful therapy and intimate relationships (Black et al., 2013). These attitudes and perceptions prevent individuals experiencing symptoms from developing the most efficacious therapeutic relationships with either medical or mental health care providers (Black et al., 2013). Furthermore, there is an unmet need for more interactive and culturally authentic relationships with treatment providers (Johnson et al., 2009).

Problem Statement

Mental illness is defined by the Center of Disease Control (CDC, 2016) as "all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning" (p. 1). It has been estimated that by the year 2020, mental illness will be the second leading cause of disability across the globe, trailing only ischemic heart disease (CDC, 2016). Mental illnesses are strongly related to the occurrence, successful treatment, and course of many chronic diseases (Greenberg et al., 2014). Diabetes, cancer, cardiovascular disease, asthma, and obesity are among the physical chronic diseases that are impacted by mental illness (CDC, 2016; Greenberg et al., 2014). Many risky behaviors (ie., physical inactivity, smoking, excessive drinking,

and insufficient sleep) are also related to mental disorders (CDC, 2016; Greenberg et al., 2014).

According to the National Institute of mental Health (NIMH), approximately 5.7 million adults in the United States or about 2.6% of the U.S population aged 18 and older are impacted by bipolar disorder (NIMH, 2016). Individuals who experience bipolar disorder may have difficulty acquiring and maintaining relationships due to the stigma associated with mental illness as a whole (Whisman et al., 2014). Bipolar disorder also is associated with poorer quality relationships due to strained and conflicted interactions that arise from one partner's care-giving responsibilities (Whisman et al., 2014). Bipolar mood swings, anxiety, and substance use affect the quality of cohabitation and intimate relationships (Whisman et al., 2014). Markers of poor mental health (ie., severe depression, suicide ideation, and suicide attempts), prevalent in many individuals with a bipolar diagnosis, may arise from inauthentic or unhealthy relationships (Kaplan, Salzer, & Brusilovskiy, 2012). Also, partner violence is more likely to occur in situations where the individual with psychiatric symptoms has not sought treatment (Lipsky, Caetano, & Roy-Byrne, 2011).

In the year 2016, African Americans used mental health services at about one-half the rate of European Americans in the same year (NAMI, 2016). Historically, attitudes and perceptions about mental illness in the African American community have been conditioned by religiosity (Tyson, 2011). In the African American community, some believe that psychiatric symptoms are a result of personal or spiritual weakness (Johnson et al., 2009). These views have interfered with treatment seeking efforts and contributed

to social isolation (Johnson et al., 2009). Lack of culturally relevant treatment options also deter African Americans from seeking treatment (Johnson et al., 2009). Apprehension about clashing with the worldview or values of the clinician can cause ambivalence about seeking treatment, and this may be true for the many who perceive that mental health treatment was designed by European American people for European American people. Many African Americans view the typical psychologist as an older, European American male, who would be insensitive to their social and economic realities (Tyson, 2011). Many African Americans have even greater stressors than their European American counter parts due to racism, prejudice, and economic disparities. A study that focuses on beliefs, attitudes, and perceptions in the African American community particularly is necessary (Tyson, 2011).

Although the aforementioned research regarding the challenges of relationship acquisition and maintenance among individuals experiencing mental illness illuminates important findings, I have found no research on the experiences and perceptions of African American individuals regarding dating persons diagnosed with bipolar disorder. Further research is warranted that could address this lack of research surrounding the social problem of stigma in the African American community associated with dating and relationships among individuals experiencing bipolar disorder.

Purpose

The purpose of this generic qualitative study as to examine the attitudes and perceptions of African American men and women regarding their experiences of being involved in dating and relationships with individuals who suffer from bipolar disorder.

The intent of this study was to illuminate the issue of bipolar disorder and relationship acquisition and maintenance within the African American community. (Seeman, 2013). In this study, I addressed the stigma surrounding mental illness, which will contribute to the existing body of literature regarding mental health and relationships. I explored the intersection of bipolar disorder, relationships, and the African American community. Individuals who have dated or been in a relationship with an individual experiencing bipolar disorder can report on their experience and describe the stages of dating and relationship acquisition and maintenance with these individuals (Barr et al., 2013).

Research Question

1. How do African American adults experience relationship acquisition and maintenance with a partner who has been diagnosed with bipolar disorder?

Framework

The theory that framed this research was equity theory. This theory was first developed in the 1960s by Adams (Reis, Aron, Clark, & Finkel, 2013). According to equity theory, people value fair treatment that causes them to be motivated to maintain fairness in the relationships with their coworkers and the work place (Reis et al., 2013). The equity structure in the workplace is based on the ratio of inputs to outcomes (Reis et al., 2013). Inputs are the contributions made by the employee for the company (Reis et al., 2013). Equity theory was later applied to situations of partners or relatives caring for cancer patients who were unable to provide as much input (Yum & Canary, 2009).

For partner support to have beneficial effects, it must be reciprocal (Reis et al., 2013). However, in the context of mental illness, relationships may be affected by the balance of

give and take between partners (Yum & Canary, 2009). Whereas support may flow back and forth between partners without the onset of mental illness, the exchange may be more unidirectional, when the healthy partner's contributions to the relationship are more than those of the individual diagnosed with a mental illness such as bipolar disorder (Yum & Canary, 2009). According to equity theory, when the ratio of contributions to rewards for one partner differ from that of the other, the relationship is imbalanced; individuals in inequitable relationships are more likely to become distressed, regardless of whether they are over benefited or under benefited (Yum & Canary, 2009). Equity theory includes an individual-level perspective on the role of the dating and relationships by focusing on individual psychological adaptation. A key advantage of equity theory is that it acknowledges the exchange of support between partners and the value that couples place on the level of equity in their exchanges related to support (Yum & Canary, 2009). There are also cultural differences in how people react to existing inequities. Individualistic cultures are more satisfied in their romantic relationships, especially when the relationship is equitable (Aumer-Ryan, Hatfield, & Frey, 2007). However, the collectivistic cultures find their relationships to be most satisfying when they were over benefitting from their relationships (Aumer-Ryan et al., 2007). Considering the emphasis placed on roles and familial kin support in collectivistic cultures such as African American culture, equity may be of less importance in affecting relationship satisfaction (Aumer-Ryan et al., 2007). However, African Americans have equity in relationships as they have historically had dual workers outside the home and shared domestic responsibilities (Aumer-Ryan et al., 2007).

Nature of the Study

This was a generic qualitative study. Generic qualitative studies have no allegiance to nor do they conform with traditional qualitative approaches such as ethnography, case studies, grounded theory, or phenomenology (Starnino, 2016). They differ in that, a) unlike ethnography, generic studies focus on the socio-cultural instead of simply the culture of a group, b) unlike case studies, generic studies focus on the sum of experiences of individuals versus that of a single case, c) unlike grounded theory, generic studies focus on deriving themes from the experiences of individuals rather than developing a theory of explanation, and lastly d) unlike phenomenology, and although closely related, generic studies focus on the "what: of an experience, while phenomenology focuses on the "how" within an experience (Starnino, 2016).

Typically, the data collection process involves a variety of methods. Some common methods include interviews, field studies, protocol analyses, and participant-observations to garner descriptions of major social trends (Starnino, 2016). Through examination and discussion of various cases, researchers can recognize actual problems, identify key players and their agendas, and become aware of the aspects of the situation that contribute to the problem (Starnino, 2016). In this study, I sought to uncover the essence of the participants' experience, attitudes, and perceptions about relationships with individuals suffering from bipolar disorder. Other approaches to this study would not be as appropriate in discovering themes related to the research question, literature, theory, and participants' responses.

Qualitative scholars emphasize trustworthiness, authenticity, and transferability (Mertens, 2017). Authenticity criteria are used for determining the goodness, reliability, validity, and rigor of qualitative research (Mertens, 2017). Trustworthiness is the extent to which a person can have confidence in the study's findings. Trustworthiness is parallel to reliability, validity, and objectivity in traditional quantitative research (Mertens, 2017). Transferability is applicability of findings based on comparability of contexts or a measure of if conditions are similar enough to make findings applicable (Mertens, 2017). To ensure creditability or internal validity, a researcher may use persistent observation. This technique involves continuing the data collection process to permit identification and assessment of salient factors, as well as investigation in sufficient detail to separate relevant or typical from irrelevant or atypical. Findings and interpretations are plausible to the researched participant and accurately reflect reality as seen by the participants (Mertens, 2017). Member checks are another technique that ensure creditability where they test veracity of the data, analytic categories (e.g., codes), interpretations, and conclusions with stakeholders to ensure accurate representation of perspectives (Mertens, 2017). Referential adequacy or the archiving of a portion of the raw data for subsequent analysis and interpretation, for verification of initial findings and conclusions, is another source of internal validation (Mertens, 2017). Thick description or describing procedures, context, and participants in sufficient detail to permit judgment by others of the similarity to potential application sites is necessary to ensure transferability or external validity (Mertens, 2017). Then, reflexive journaling where the researcher's personal notes and documentation of the researcher's thinking throughout the research

process can ensure credibility (internal validity), transferability (external validity), dependability, and confirmability (reliability and objectivity; Mertens, 2017).

Definitions

Bipolar disorder (manic-depressive illness): A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks (NIMH, 2016).

Mental illness: All diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (CDC, 2016).

Relationship acquisition: The dating process where a relationship is developed (Barr et al., 2013).

Relationship Maintenance: Relationship behaviors revolving around positivity, openness, assurances, social networks, conflict management, and tasks (Barr et al., 2013).

Assumptions

Qualitative researchers approach a study with a basic set of beliefs or assumptions that guide inquiry (Read, 2016). One assumption for this study was that all participants would tell the truth and answer the interview questions in an honest and candid manner (Fletcher, 2017). Also, an assumption of this study was that all participants will be open and forthcoming regarding their relationship experiences and that all who participate will be willing to share these experiences (Oye, Sorensen, & Gladsdam, 2016). Another assumption of this study was that inclusion criteria of the sample were appropriate; I assured that the participants were African American adults who had all experienced

dating or being in a relationship with an individual diagnosed with bipolar disorder (Granek & Nakash, 2016). Furthermore, I assumed that participants had a sincere interest in participating in this study and do not have any other motives, such as receiving a reward to participate in this study (Wahlstorm, 2017).

Scope and Delimitations

The current study had a scope and delimitations that restricted the research question that can be answered. African Americans in relationships with persons experiencing any mental illness other than bipolar disorder were not within the scope of this study. I was not looking at African Americans in relationships in general, but African Americans who had been in relationships or dated an individual diagnosed with bipolar disorder. Furthermore, my sample did not consist of individuals with bipolar disorder, but rather the healthy partner. The boundaries set for this study can facilitate interpretation of the results and help arrive at meaningful conclusions (Mertens, 2017).

Limitations

A limitation to the current study was that the small number of cases does not offer grounds for establishing reliability or generalizability of the findings (Fletcher, 2017). The 10 to 12 of participants in this study were not enough from which to adequately draw conclusions but was at a level in which saturation of the data should be achieved (Fletcher, 2017). Although generalizability is not the goal of qualitative research, it is still worth mentioning as a limitation to this study (Fletcher, 2017). Another limitation is my bias as the researcher. My subjectivity can affect the interpretation of the data and recognizing this can help to overcome this limitation (Fletcher, 2017). Also, there were

limitations regarding participants' ability or willingness to share their experiences about dating individuals diagnosed with bipolar disorder (Fletcher, 2017).

Significance

According to the CDC (2016), only 25% of adults surveyed with mental health symptoms believe that people are caring and sympathetic to persons with mental illness. The CDC found that three quarters (75%) of people surveyed living with a mental health problem reported that they fear disclosing their disorder to their partner for the first time. One in 10 people surveyed with a psychiatric illness said it took them over a year to finally disclose their mental illness to a new partner (CDC, 2016). Individuals experiencing bipolar disorder may fear confiding in others about their symptoms due to social stigma (Seeman, 2013). Furthermore, within social networks, stigmatizing attitudes regarding psychiatric disorders may discourage the use of psychiatric medication among individuals experiencing psychiatric symptoms (Johnson et al., 2009). This study is significant because it will contribute to a body of existing literature on mental health and relationships. Furthermore, this study promotes learning and understanding about bipolar disorder and the impact of mental illness on relationships, particularly within the African American experience (Whitton, Weitbrecht, Kuryluk, & Bruner, 2013).

Summary

In this study, I examined attitudes and perceptions of African Americans regarding dating and relationships with individuals experiencing bipolar disorder. The purpose of this study was to fill an existing gap in the literature. Mental health, bipolar

disorder, relationship acquisition, and relationship maintenance were defined in this chapter. The research question for this study was on how adults in the African American community experience relationship acquisition and maintenance when a partner has been diagnosed with bipolar disorder. Psychiatric disorders have an impact on romantic relationships (Barr et al., 2012). The nature of the study involved a qualitative approach. Specifically, a generic qualitative study was used in this study (Precht, Espino, Perez, Ingram, Amodei, Miller, & Gonzalez, 2015). In the next chapter, I will review the existing literature on this topic.

Chapter 2: Literature Review

Introduction

Mental illness is a global concern that can lead to a variety of difficulties for the individual, family members, and the wider community (Kaplan et al., 2012; Tyson, 2011; Whisman et al., 2014). Bipolar disorder is a mental illness that is of particular concern as it can disrupt the development of healthy, balanced relationships (Kaplan et al., 2012; Tyson, 2011; Whisman et al., 2014). Romantic relationships have implications for a person who struggles with bipolar disorder (Kaplan et al., 2012). Although much has been written about the impact of bipolar disorder on relationships and the impact of romantic relationships on individuals experiencing bipolar disorder and their partners, certain groups, such as African Americans, appear to be under represented in these studies (Kaplan et al. 2012; Murray et al., 2017; Swartz & Swanson, 2014; Whisman et al., 2014). This is of particular concern as African Americans make up a larger percentage of persons diagnosed with bipolar disorder (Tyson, 2011). The purpose of this generic qualitative study was to explore the lived experience of African American adults who had dated or been in relationships with individuals diagnosed with bipolar disorder. The goal of this study was to gain an understanding of the attitudes and perceptions within the African American community about dating and relationships with individuals experiencing bipolar disorder and to determine how these perceptions may impact relationship attainment and success.

A literature review is designed to provide an understanding of a problem and to validate that topic as worthy of further research (Reis et al., 2013). It is also designed to

demonstrate how a study is situated within the existing body of scholarly literature and to provide a benchmark for comparing the results of the study with other findings (Precht et al., 2015; Starnino, 2016). This research was about the nature of relationship acquisition and maintenance as a foundation for dating or embarking on a relationship with an individual experiencing bipolar disorder. To conduct this study, I first considered available research about African Americans who are or have been in relationships with individuals experiencing bipolar disorder.

I will provide a description of the literature review strategies that I used to locate seminal research and current, peer-reviewed studies or other relevant works. The goal of Chapter 2 is to provide a comprehensive analysis and appraisal of current literature as it relates to the following identifying criteria: bipolar disorder, bipolar disorder and relationships, African Americans and bipolar disorders, and African American relationships. After an exhaustive review of the literature, I was unable to find research that focuses on the dating and relationship experiences between African Americans and individuals diagnosed with bipolar disorder from the perspective of the partner.

Literature Research Strategies

To provide an effective review of the literature, I used a writing strategy that began with a focus on the broad topic, bipolar disorder. I then narrowed the focus to attitudes and perceptions among African American adults about dating and relationships with individuals experiencing bipolar disorder. The identifying criteria for this academic work included several overlapping subject areas and fields of study. Various databases and search engines were used to locate professional journals and other peer-reviewed

sources and to identify germane scholarship. I searched the Walden University library using search engines such as PsycINFO, SocINDEX, PsycINFO, Health and Psychosocial Instruments (HaPI), and MEDLINE. I also consulted ProQuest Central to pursue lines of inquiry related to the study and SAGE journals and Google Scholar to find relevant, peer-reviewed articles. Local statistical information was sourced from the CDC and NIMH websites. To locate scholarly and peer-reviewed articles, I used combinations of the following keywords and terms by employing Boolean identifiers to search the above mentioned data bases: *mental illness, bipolar disorder, African Americans, dating, relationships, acquisition, maintenance, disclosure,* and *stigma.* Several articles emerged from various authors. I focused on the articles published within the past 5 years.

Theoretical Framework

The theory that framed this research was equity theory. This theory was first developed in the 1960s by Adams (Reis et al., 2013). According to equity theory, people value fair treatment which creates the motivation to maintain fairness in relationships with their colleagues and within the organization (Reis et al., 2013). The basis of the equity structure in the workplace is the inputs to outcomes ratio (Reis et al., 2013). Inputs are the contributions an employee makes for the organization (Reis et al., 2013). Equity theory was later applied to situations of partners or relatives caring for cancer patients who were unable to provide as much input (Yum & Canary, 2009).

Some research suggests that partner support must be reciprocal to have beneficial effects (Reis et al., 2013). However, in the context of mental illness such as bipolar disorder, relationships may be impacted by the couple's balance of give and take (Yum &

Canary, 2009). Whereas a couple's support may flow back and forth without the onset of bipolar disorder, there may be more of a unidirectional exchange with the healthy partner's contributions to the relationship far exceeding those of the individual diagnosed with a mental illness such as bipolar disorder (Yum & Canary, 2009). According to equity theory, when the ratio of contributions to remuneration for one partner differs from that of the other, the relationship is inequitable; individuals in unbalanced relationships are more likely to become distressed, regardless of whether they are over compensated or under compensated (Yum & Canary, 2009). Equity theory adopts an individual-level perspective on the role of dating and relationships by acknowledging individual psychological adaptation. A chief benefit of this theory is that it focuses on support exchanges between partners and the value that partners attach to equity levels in their exchanges related to support (Yum & Canary, 2009).

Individuals evaluate their relationships with others by assessing the ratio of their outcomes from and inputs to the relationship against the outcome/input ratio of the other person in the relationship (Huseman, Hatfield, & Miles, 1987). If the outcome/input ratios of an individual and the other person in the relationship are perceived to be unequal, then inequity exists (Huseman et al., 1987). The greater the inequity the individual perceives in the form of either over benefitting or under benefitting, the more distress the individual experiences (Huseman et al., 1987). The greater the distress an individual experience, the harder he or she will work to restore equity, thus reducing the distress (Huseman et al., 1987). The presence of inequity will motivate an individual to

achieve equity or reduce inequity, and the motivation to do so will vary directly with the amount of inequity (Adams, 1963).

Actions that may be available means to reduce inequity may not be as easy to facilitate when one individual in the relationship is experiencing psychiatric symptoms (Swartz & Swanson, 2014). An individual may increase inputs if he or she is low relative to the partner's inputs and his or her own outcomes, or decrease inputs if they are high relative to the partner's inputs and his or her own outcomes (Adams, 1963). For example, if the individual with bipolar disorder's efforts were low compared to his or her partner, the individual could reduce inequity by increasing his or her effort to increase productivity at work or by enhancing the quality of work. This can increase pay and total income between the partners (Adams, 1963). However, work is often a facet of life negatively impacted by mental illness such as bipolar disorder (Swartz & Swanson, 2014). If inputs other than effort were involved, the individual experiencing symptoms of mental illness could perhaps increase his or her training or education. Where some inputs are not easy to alter such as sex and ethnicity, the individual contributing less should adopt other means of reducing inequity (Adams, 1963). The individual contributing less inputs could also, if appropriate, acquire additional benefits, perquisites, or status (Adams, 1963). An increase in status could create new problems, however, and questions still lie in the efficacy of the individual with the mental disorder (Swartz & Swanson, 2014). Other available options to decrease inequity in a relationship involve the individual with higher outcomes taking a cut in pay or leaving his or her career (Adams, 1963). These modes of reducing inequity are radical and improbable, yet theoretically

possible (Adams, 1963). Other techniques to restore equity include altering or cognitively distorting inputs or outcomes or terminating the relationship (Huseman et al., 1987). The nature of the input and outcome discrepancies and environmental circumstances may render some modes more available than others, as may personality characteristics of each partner (Adams, 1963).

Other norms appear to contradict the norm of equity regarding reward allocations or how individuals distribute outcomes among recipients (Huseman et al., 1987). Three distribution rules that an individual might employ when allocating outcomes to others include (a) the contribution (equity) rule, where receivers are rewarded outcomes in proportion to their inputs; (b) the needs rule, where others are rewarded based upon their legitimate needs; and (c) the equality rule, where others receive equal outcomes irrespective of their individual inputs (Huseman et al., 1987). Different norms govern the allocation of rewards. Also, allocators do not universally adhere to the equity norm when distributing outcomes to recipients. The norm of equity has exceptions, at least in terms of how a person allocates to others (Huseman et al.,1987). These exceptions are important to relationships where one individual may be incapable of increasing inputs and outcomes. Other exceptions to the norm of equity take into account demographic variables (Huseman et al., 1987).

Huseman et al. (1987) proposed the construct of equity sensitivity to explain individual differences in reactions to inequity. According to equity theory, individuals who perceive themselves as either under benefitted or over benefitted will experience distress and try to restore equity (Huseman et al., 1987). Reactions to inequity are a

function of an individual's preferences for a different outcome–input ratio (Huseman et al., 1987). The equity sensitivity construct proposed relates directly to equity theory and suggests that individuals react consistently, but in individually different ways to both perceived equity and inequity. Individuals have different preferences for equity (Huseman et al., 1987).

Another aspect of equity theory that is important to understanding relationship involvement with an individual experiencing a mental illness such as bipolar disorder is the concept of benevolence. The conceptual roots of benevolence can be traced to the categorization of an individual's reactions to others in interpersonal relationships (Huseman et al., 1987). Salient categories include the "socially useful" and a person who "thinks more of giving than receiving" (Huseman et al., 1987). Benevolent preferences may vary among different heritages where a particular culture may promote the philosophy of high inputs for self with little regard for outcomes (Huseman et al., 1987). Social responsibility, as opposed to equity or reciprocity, is a potential motivating force for altruistic behavior (Huseman et al., 1987). Furthermore, empathy motivates individuals to act altruistically; that is, individuals are aroused to sacrifice their own interest in favor of others due to the vicarious experience of other's needs (Huseman et al., 1987). However, the bulk of the research into altruism is short-term oriented, focusing on temporary or transient relationships such as those between bystanders and others who need their assistance (Huseman et al., 1987). Thus, a benevolent might perceive real or imagined needs and, thus, be inclined to emphasize his or her own inputs over outcomes. A less consistent perception of benevolence suggests that altruistic

behavior represents disguised self-intert. Thus, a benevolent's preference for lower outcome/input ratios than that of the other in the relationship might emanate either from a need for social approval or a desire to enhance his or her self-image (Huseman et al., 1987). Generally, benevolents are givers and their contentment is derived from perceptions that their outcome/input ratios are less than the other person in the relationship. Distress occurs for benevolents either when the ratios are equal or when the benevolent's ratio is greater (Huseman et al., 1987).

Equity preferences may also vary by culture (Aumer-Ryan et al., 2007). Aumer-Ryan et al. (2007) applied equity theory to the study of culture's role between perceived equity in an individual's romantic relationship and relationship satisfaction. A significant interaction was found between culture and equity in predicting relationship satisfaction (Aumer-Ryan et al., 2007). In both groups, participants considered equity to be of critical importance in romantic relationships (Aumer-Ryan et al., 2007). However, men and women in the individualistic group generally considered their relationships to be slightly more equitable and far more satisfying than did people in the collectivistic group (Aumer-Ryan et al., 2007). There were also cultural differences in how people reacted to existing inequities. The individualistic group sample was more satisfied in their romantic relationships, especially when the relationship was equitable (Aumer-Ryan et al., 2007). However, the collectivistic group sample found their relationships to be most satisfying when they were over benefitting from their relationships (Aumer-Ryan et al., 2007). The collectivist culture affected the relationship between equity and relationship satisfaction (Aumer-Ryan et al., 2007). Considering the emphasis placed on roles and familial kin

support in collectivistic cultures such as African American culture, equity may be of less importance in affecting relationship satisfaction (Aumer-Ryan et al., 2007). However, African American relationships have historically tended to be more equal in regard to dual work outside the home and shared in home duties (Aumer-Ryan et al., 2007). At the same time, African Americans provide more care than their European American counterparts. African Americans also experience less stress and depression and garner greater rewards from caregiving than European American caregivers, which reinforces the notion that equity may be of less importance among African Americans (Aumer-Ryan et al., 2007).

Bipolar Disorder

Bipolar disorder is a mental disorder signified by alternating periods of depression and elation (NAMI, 2016). There are several types of bipolar disorder, and characteristics may include depression and mania or hypomania (Murray et al., 2017; NAMI, 2016). Symptoms may result in unpredictable swings in mood and behavior, leading to significant distress (Murray et al., 2017; NAMI, 2016). Bipolar I disorder may be present if an individual has had at least one manic episode that may be preceded by or subsequent to a major depressive or hypomanic episode (Swartz & Swanson, 2014). In certain cases, mania can trigger psychosis or a break from reality (Swartz & Swanson, 2014). Bipolar II disorder is marked by at least one hypomanic episode and at least one major depressive episode and at least one hypomanic episode, but not a manic episode (Swartz & Swanson, 2014). Bipolar II disorder is not a milder form of bipolar I disorder, but is a separate diagnosis (NAMI, 2016). Although the manic episodes of Bipolar I

disorder can be dangerous and severe, Bipolar II disorder can lead to longer periods of depression that can significantly impair the individual (NAMI, 2016). Other types of bipolar disorder include disorders induced by particular drugs or alcohol or because of a medical condition, such as a stroke or multiple sclerosis. Cyclothymic disorder can be detected if an individual has had at least 2 years as an adult or 1 year as a child or teenager, of several periods of hypomania and less severe depressive symptoms (NAMI, 2016). Bipolar disorder can occur at any age, although it is typically diagnosed in the teenage years or in the early 20s (Swartz & Swanson, 2014). Symptoms can vary over time and from person to person (Swartz & Swanson, 2014).

Major Depressive Episode

A major depressive episode consists of symptoms that are severe enough to predicate noticeable difficulty in everyday activities, such as school, work, social activities, and relationships (NIH, 2015). An episode consists of five or more of the following symptoms:

- Either sleeping too much or insomnia
- Either dilatory behavior or restlessness
- Loss of energy or fatigue
- Depressed mood, such as feeling hopeless, sad, empty, tearful, or irritable
- Feelings of inappropriate or excessive guilt or worthlessness
- Suicide ideation
- Loss of interest or decreased feelings of pleasure in most activities previously enjoyed

- Indecisiveness or reduced ability to think or concentrate
- Significant weight loss without dieting, weight gain, or increase or decrease in appetite (NIH, 2015).

Signs and symptoms of Bipolar I disorder and Bipolar II disorders may include other features, such as psychosis, anxious distress, and melancholy (NIH, 2015). The temporality of symptoms may consist of diagnostic labels such as rapid or mixed cycling (NIH, 2015). Delusions and hallucinations may be indicative of severe episodes of bipolar disorder. Bipolar symptoms may also occur during pregnancy or seasonally (NIH, 2015).

Causes of Bipolar Disorder

The exact cause of bipolar disorder is unknown; however, genetics, environment, chemistry, and altered brain structure combined are generally believed to play a role (Murray et al., 2017). Extant academic theories of bipolar disorder can be categorized as biological, genetic, and psychosocial (Murray et al., 2017). Genetic scholars show that bipolar disorder is one of the most inheritable mental disorders; therefore, many theories are genetically based and focused. Biological theories consider hypothalamic–pituitary–adrenal axis and neurotransmitter system abnormalities (Murray et al., 2017). Other biological theories suggest that sleep deprivation and a disruption of circadian rhythms can induce mania (Reinares et al., 2016). Where there is a high genetic determination in bipolar disorder, it helps with the medicalization of the problem and the normalization of medication use (Reinares, et al, 2016).

Although it is important for the individual and the clinician to recognize the strength of biology as a contributing factor to bipolar disorder, stress in the form of interpersonal conflicts, life events, expressed emotion, and the paucity of stress-management skills exacerbate the outcome (Reinares et al., 2016). There is considerable evidence that coping skills, life events, and family environment contribute to the manifestation of manic and depressive disorders (Murray et al., 2016). Psychosocial theories of aetiology suggest stressful life events and dysfunctional attempts to evade depression (Murray et al., 2016). The dysregulation of self-esteem and childhood abuse and trauma have also been linked with bipolar disorder (Reinares et al., 2016).

Implications of Bipolar Disorder

Bipolar disorder is the sixth most common cause of disability in the United States (Miklowitz &Gitlin, 2015). Completed suicide rates for bipolar disorder are 60 times higher than that of the general population, with a much higher rate of completed suicides for each attempt: 1:3 individuals with Bipolar Disorder versus 1:30 in the general population (Miklowitz &Gitlin, 2015). Quality of life is often compromised for individuals experiencing bipolar disorder (Stein, Celedonia, Swartz, Burns, Sorbero, Brindley, & Frank, 2015). Implications of the disorder include higher unemployment, lower wages, work absenteeism, workmen's compensation reliance, lower levels of educational attainment, higher rates of divorce, and higher arrest and hospitalization rates (Johnson & Johnson, 2014). Bipolar disorder is not only exacerbated by negative life events such as job or relationship loss, but may also exacerbate such life events (Stein, et al, 2015). Individuals who are inclined towards negative cognitive styles and lack the

skills to resolve conflicts, solve daily problems or regulate emotion, are more likely to have recurrent episodes that necessitate hospitalization (Johnson & Johnson, 2014). Family context and conflict emerge as especially problematic (Johnson & Johnson, 2014). High expressed negative emotion adds a significantly greater risk to mental illness. There has been increased attention paid in recent years to medical comorbidity, including obesity, to characterize this issue of higher risk due to expressed negative emotion (Johnson & Johnson, 2014). At an escalating rate, coronary heart disease, hypertension, diabetes, hyperthyroidism, dysplidemias, and hepatitis contribute to comorbidity of bipolar disorder (Johnson & Johnson, 2014). Individuals with bipolar disorder also exhibit elevated rates of smoking, drug, and alcohol abuse. Poorer self-care indicated by less exercise, inactive lifestyles, and minimal medical care can contribute to higher obesity rates (Johnson & Johnson, 2014). Elevated risk of pulmonary embolism may also be a ramification of obesity and lifestyle factors in individuals with bipolar disorder (Johnson & Johnson, 2014). These medical conditions only exacerbate the struggles, stress, and depression, and the bipolar disorder itself (Johnson & Johnson, 2014).

Diagnosing Bipolar Disorder

African American, Hispanic, and other minority populations are often underdiagnosed with bipolar disorder, contributing to a greater risk of negative outcomes (Miklowitz &Gitlin, 2015). Many individuals have been misdiagnosed with unipolar depression (Miklowitz &Gitlin, 2015). Furthermore, few individuals voluntarily present their complaints to a therapist regarding manic symptoms such as hypersexuality and

grandiosity (Miklowitz &Gitlin, 2015). To make matters more complicated, many individuals with bipolar disorder not only lack insight into their mania, but recollections of their manic episodes are often poor (Miklowitz &Gitlin, 2015). Thus, it may be necessary to consult with family members on a regular basis in order to garner a more accurate history (Miklowitz &Gitlin, 2015). Recent interest in mania and hypomania phenomenology, including the development of forms for self-reporting mania, can aid in identifying symptom patterns (Stein, Celedonia, Swartz, Burns, Sorbero, Brindley, and Frank, 2015). The adequate diagnosis of mania and hypomania may be the single most important step preceding medication in the treatment of bipolar disorder (Stein, et al, 2015).

Treatment Related to Quality of Life

Geddes and Miklowitz (2014) reviewed recent developments in acute and long-term bipolar disorder treatment and identified promising and innovative routes to therapy. Overall, drug treatment advances remain modest (Geddes & Miklowitz, 2014). Although considerable uncertainty and controversy remains about the use of antipsychotic drugs to treat depressive episodes, antidepressant drugs are efficacious in acute mania treatment (Geddes & Miklowitz, 2014). The efficacy of antipsychotics is variable in the management of depression (Geddes & Miklowitz, 2014). Even with optimal pharmacotherapy or therapy using pharmaceutical drugs, many individuals with bipolar disorder are slow to recover from episodes of illness (Miklowitz & Gitlin, 2015). Pharmacotherapy alone is also associated with high recurrence rates and significant functional impairment (Miklowitz & Gitlin, 2015). There has been notable progress in

adjunctive psychosocial intervention development and assessment (Miklowitz & Gitlin, 2015). A combination of psychosocial treatments along with drugs can enhance long-term stabilization and possibly acute management of depression (Geddes & Miklowitz, 2014). Miklowitz and Gitlin (2015) studied randomized psychotherapy trials as pharmacotherapy adjunct. The researchers found evidence for the efficacy of group psychoeducation, family-focused interventions, social rhythm therapy, interpersonal therapy, and cognitive-behavioral therapy in relapse delay, prevention, and illness episode stabilization (Miklowitz & Gitlin, 2015). Although these treatments share many common strategies such as psychoeducation, there is minimal information about how they work and how large numbers of clinicians should be trained in these treatments. There have been strides in the development of online versions of psychoeducational care (Miklowitz & Gitlin, 2015).

It is important to understand bipolar disorder, treatment approaches, and discerning hindrances to optimal care. Researchers agree that the most efficacious psychosocial interventions utilize standard strategies, such as psychoeducation as well as medication adherence promotion, regular daily routine and sleep encouragement, mood monitoring, and early detection of relapse warning signs (Stein, et al, 2015; Miklowitz & Gitlin, 2015). The Incorporation of interventions that are evidence-based into a routine of community clinical practice has the potential to improve outcomes for many individuals experiencing bipolar disorder (Stein, et al, 2015). The effectiveness of implementation strategies for evidence-informed treatment could be enhanced if they build on the skills and extant knowledge of the clinicians involved in providing treatment (Stein, et al,

2015). This study explored empirical research regarding the strategies routinely used by clinicians who provide treatment for bipolar disorder in community practices (Stein, et al, 2015).

Swartz and Swanson (2014) also stated that although the mainstay of bipolar disorder management is pharmacotherapy, only partial relief is offered through medication. These researchers suggested that therapy specific to bipolar disorder be increasingly recommended as a core component of disorder treatment (Swartz & Swanson, 2014). They also conducted a search of the literature for outcome studies identifying 35 reports of 28 randomized controlled trials evaluating individual or group psychosocial interventions for bipolar adults (Swanson & Swanson, 2014). These reports include systematic trials examining the effectiveness and efficacy of individual psychoeducation, group psychoeducation, individual cognitive-behavioral therapy, group cognitive-behavioral therapy, family therapy, interpersonal and social rhythm therapy, and integrated care management. The evidence demonstrated psychotherapies specific to bipolar disorder in addition to medication, show consistent advantages over medication alone on symptom burden measures and relapse risk. Whether provided in individual or group format, those who received psychotherapy specific to bipolar disorder reaped more benefits than those who did not (Swanson & Swanson, 2014).

Management of Bipolar Disorder

According to the Substance Abuse and Mental Health Services Administration (SAMSHA), mental health management is a journey of healing and transformation that enables an individual with mental health issues to live a meaningful life in a community

of his or her choice while striving to achieve his or her full potential (SAMSHA, 2017). Interventions that promote hope, respect, and self-directed empowerment make it possible to facilitate management of bipolar disorder. Getting past shame and self blame is part of initiating management (Tse, Murray, Chung, Davidson, Ng, & Yu, 2014). Setting goals and having faith can also boost management efforts (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013). Borg, Veseth, Binder, Per-Einar and Alain (2013) employed a reflexive methodology and uncovered themes of the meaning and focus of work, helpful roles and context, living as more than a person with an illness, supportive relationships, and supportive medication as aiding in management of bipolar disorder (Borg, et al, 2013). There may be challenges associated with work and social activity for individuals experiencing bipolar disorder, thus it is important to find a meaningful and healthy balance (Borg, et al, 2013).

Werner (2012) examined serious mental illness (SMI), including bipolar disorder, in order to promote management. The study explored the needs of individuals with SMI and juxtaposed their perceptions to those of their professional caregivers (Werner, 2012). Needs were reported in the areas of psychotic symptoms, intimate relationships, accommodations, daytime activity, and psychological distress (Werner, 2012). More met needs were reported by caregivers, while more unmet needs were reported by the individuals themselves (Werner, 2012). The findings implied that in order to promote management, services for individuals with SMI should be generated in accordance with patients' most salient needs (Werner, 2012).

Murray et al. (2017) asserted that current adjunctive psychosocial interventions for bipolar disorder aim to impact the course of the illness via information sharing and skill development (Murray et al., 2017). This focus on clinical outcomes contrasts with the emergent recovery paradigm, which prioritizes adaptation to serious mental illness and gravity towards personally meaningful goals (Murray et al., 2017). The aim of this study is to prompt innovation in the psychological management of bipolar disorder by examining management-oriented trends in the literature (Murray et al., 2017). One management-oriented target is quality of life (Murray et al., 2017). Another management target is the staging approach with psychosocial interventions tailored to bipolar disorder stages (Murray et al., 2017). The study also reveals evidence of mindfulness-based psychosocial interventions as having potential in regard to management across early, middle, and late stages of bipolar disorder (Murray et al., 2017). This study concluded that the humanistic emphasis on management provides an opportune stimulus for development of next generation psychosocial treatments for individuals with bipolar disorder (Murray et al., 2017).

Jones, Mulligan, Higginson, Dunn, and Morrison (2013) assessed the importance of personal management in mental health. They sought to measure management experiences in individuals with Bipolar Disorder (Jones, et al, 2013). The researchers developed a Bipolar Recovery Questionnaire (BRQ) as auxiliary to clinical practice and research developments that are recovery informed (Jones, et al, 2013). The BRQ draft consisted of items based on previous literature reviews and qualitative research (Jones, et al, 2013). A panel of academics, clinicians, and consumers ranked the relevance and

comprehensibility of the items leading to a questionnaire that underwent psychometric evaluation (Jones, et al, 2013). Participants with bipolar disorder completed the BRQ along with measures of mood, functioning, personal growth, and quality of life (Jones, et al, 2013). The BRQ scores were significantly correlated with lower mania and depression and scores and with higher wellbeing (Jones, et al, 2013). The scores from the BRQ also had a significant association with better mental health, functioning, personal growth, and quality of life (Jones, et al, 2013). Wellbeing, personal growth, and depression had unique correlations with BRQ as indicated by regression analysis (Jones, et al, 2013). A limitation of the BRQ is that it was designed to evaluate personal experiences of management of bipolar individuals (Jones, et al, 2013). However, associations with both functional and symptomatic outcomes consistent with extant recovery definitions established consistency and reliability (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013). Reinares et al. (2016) have also stated that functional and symptomatic improvement have become aims of recovery from bipolar disorder.

Bipolar Disorder and Attachment

Social relationships and attachment are evolutionary components at the core of human existence and survival that develop over an individual's lifetime (Greenberg et al., 2014). The immediate environment or the presence of illness in the individual are the internal and external factors that influence these elements (Greenberg et al., 2014). Social relationships and attachment have developmental aspects that have garnered increased interest and relevance in light of gene expression's early developmental studies on changes in organisms (Greenberg et al., 2014). These epigenetic changes are caused

by modifications of gene expression or appearance of a gene's corresponding character that may impact subsequent behavioral outcomes (Greenberg et al., 2014). These researchers explored extant literature on social relationships and attachment in bipolar cohorts (Greenberg et al., 2014). The results of their study suggested that individuals with bipolar disorder have a significantly compromised potential for social relationships and attachment (Greenberg et al., 2014). Though the existing research is limited, the research revealed the significance of social relationships on bipolar disorder's etiology, course, and consequences (Greenberg et al., 2014).

Research has shown that more negative relationship quality in social relationships such as marriage and other intimate relationships presented cross-sectional and longitudinal correlations with various psychiatric disorders in adults (Whisman et al., 2014). Sheets and Miller (2010) suggested that marital functioning was a significant predictor particularly of bipolar disorder's course. Research indicated that individuals experiencing depressive symptoms are correlated with those individual's ratings of couple functioning and general family functioning, while individuals with manic symptomatology correlated with romantic relationships (Sheets & Miller, 2010). An individual's pathology impacts the perception of the couple's relationship (Sheets & Miller, 2010). The pervasiveness of broad characterizations of mood, anxiety, and substance use disorders, and many other specific disorders are significantly correlated with poorer relationship quality in regard to marriage, cohabitation, and serious relationship involvement (Whisman et al., 2014).

Although there is evidence to support that individuals with bipolar disorder are at higher risk for non-supportive relationships and interpersonal dysfunction, efforts to understand the association between bipolar disorder and relationship functioning are limited (Rowe & Morris, 2012). There has been more research done on unipolar disorder despite research that suggests bipolar disorder is more severe and chronic (Rowe & Morris, 2012). A study by Rowe and Morris (2012) addressed a gap in the literature by examining the correlations among individuals with bipolar disorder, symptoms of mental illness their partner's may experience, and relationship functioning. This study employed a multi-respondent, multimethod approach (Rowe & Morris, 2012). The results of the study revealed that depressive symptoms in individuals experiencing bipolar disorder correlated with poorer relationship functioning, especially when the partner without bipolar disorder also has symptoms of mental illness (Rowe & Morris, 2012). Rowe and Morris (2012) observed an interaction between partners where one was experiencing bipolar disorder and the other partner had elevated symptoms. The symptoms were associated with an observation of poorer partner relationship adjustment and increased hostility, but only when the symptoms were elevated (Rowe & Morris, 2012). These effects were persistent even after controlling for the overall mental health of both partners (Rowe & Morris, 2012).

For several disorders, the relationship between a mental disorder and relationship involvement has been moderated by age, wherein with increasing age, the strength of the correlation decreased in magnitude (Whisman et al., 2014; Soller, 2014). The adolescent years of an individual experiencing mental illness is a developmental

period that is correlated with a greater risk of incidence of several disorders and that is significant for the acquisition and maintenance of intimate relationships (Whisman et al., 2014). Age as well impacts relationship authenticity. Soller (2014) explored the mental health repercussions of inauthenticity within romantic contexts and incongruence between thoughts/feelings and actions in romantic relationships. Correlations with severe depression, suicide ideation, and suicide attempts were tested by the researcher (Soller, 2014). Results showed that inauthenticity in romantic relationships was positively correlated with all three of the aforementioned risk markers of poor mental health, but only for girls (Soller, 2014).

Bipolar Disorder and Intimate Partner Violence

Although it is a common misconception that most individuals with mental illness are violent, Lipsky et al.(2011) explored the relationship between intimate partner violence (IPV) perpetration, substance use, serious mental illness, and the necessity for mental health treatment among men in the general population using the behavioral model for health-care use. This study utilized a national survey on drug use and health of Non-Hispanic Black, Hispanic, and non-Hispanic white males ages 18–49 years who were cohabiting with a partner/spouse (Lipsky et al., 2011). Results of this study suggested that the proportion of men reporting unmet mental health care needs was greater among IPV perpetrators than nonperpetrators (Lipsky et al., 2011). Illicit drug use, hazardous drinking, drug and alcohol dependence/abuse, and serious mental illness (SMI) were also more common among perpetrators (Lipsky et al., 2011). Perpetrators were twice as likely to report their treatment needs as unmet after

considering factors of enabling, predisposing, and need (Lipsky et al., 2011). Alcohol dependence/abuse, drug dependence/abuse, substance abuse treatment, and SMI were independently correlated with perceived unmet needs for treatment (Lipsky et al., 2011). In conclusion, men with unmet mental health treatment needs and serious mental illness are more likely to be perpetrators of intimate partner violence (Lipsky et al., 2011).

Hypersexuality

Researchers have recognized shifts in sexual behavior as an intrinsic part of bipolar disorder, but most of the relevant literature on sexual matters in individuals with this disorder focused on the side effects of medication and did not differentiate bipolar disorder from other serious mental illnesses (Kopeykina, Kim, Khatun, Boland, Haeri, Cohen, & Galynker, 2016). Kopeykina, Kim, Khatun, Boland, Haeri, Cohen, and Galynker (2016) conducted a study that focused on mania-induced hyper-sexuality and the impact of mood cycling on intimate relationships**.** The researchers examined the existing literature and proposed a framework for future studies. Results revealed that although there is variability in diagnosis of bipolar disorder and no formal definition of hyper-sexuality, the literature suggested an elevated incidence of risky sexual behaviors in individuals with bipolar disorder during manic episodes in comparison to individuals with other psychiatric disorders (Kopeykina, Kim, Khatun, Boland, Haeri, Cohen, & Galynker, 2016). Furthermore, the research indicated that individuals experiencing bipolar disorder are more similar to healthy people than to individuals with other psychiatric diagnosis when it comes to relationships acquisition and maintenance (Kopeykina, Kim, Khatun, Boland, Haeri, Cohen, & Galynker, 2016).

Nonetheless, studies have shown in relationships with one bipolar partner, sexual satisfaction levels were decreased, sexual interest levels varied across polarities, sexual dysfunction incidences during depressive episodes increased, and disparate satisfaction in general in relationships with one bipolar individual (Kopeykina, Kim, Khatun, Boland, Haeri, Cohen, & Galynker, 2016). This study pertained to sexual problems that are specific to diseases such as bipolar disorder, hyper-sexuality, induced by mania, and specific effects of mood cycling on romantic relationships (Kopeykina, Kim, Khatun, Boland, Haeri, Cohen, & Galynker, 2016).

The Stigma of Bipolar Disorder

Oliveira, Esteves, and Carvalho (2015) suggested that severe stigmatization exists in regard to mental illness and mental health care environments. The stigmatization may be related to deteriorated self-esteem and decreased social relationships quality for individuals with mental illness (Oliveira, Esteves, & Carvalho, 2015). The researchers sought to identify clinical profiles characterized by diagnoses that are related to the treatment settings and correlated with internalized stigma, social relationships satisfaction, and self-esteem (Oliveira, Esteves, & Carvalho, 2015). Furthermore, this study analyzed correlations between clinical profiles and socio-demographic characteristics (Oliveira, Esteves, & Carvalho, 2015). Findings showed that the pervasiveness of internalized stigma persist for many individuals with mood disorders (Oliveira, Esteves, & Carvalho, 2015). Particularly, internalized stigma and dissatisfaction with social relationships and related socio-demographic characteristics seemed to be a risk factor for social isolation for individuals with mood disorders, which

may lead to the worsening of the disorder's course (Oliveira, Esteves, & Carvalho, 2015). The results shed light on the significance of structured intervention development that targets internalized stigma and exclusion of those who suffer from social role and network losses (Oliveira, Esteves, & Carvalho, 2015). Another study suggested also that within social networks, stigmatizing attitudes about mental health disorders may discourage the use of psychiatric medication among individuals with psychiatric illness (Johnson et al., 2009).

Social Support for Persons with Bipolar Disorder

A study by Townley, Miller, and Kloos (2013) focused on intimate relationships along with the role of casual relationships that exist naturally in the community. The researchers highlighted the significance of considering diverse types of social support including intimate relationships in naturally occurring settings when designing interventions and treatment plans with a target of encouraging social activity and community participation for persons with mental health disorders (Townley, Miller, & Kloos). Kaplan et al. (2012) sought to promote recovery and quality of life as the major focus of transformation efforts for local and national mental health care systems. The study showed that individuals experiencing psychiatric disorders who participated in more social activities had higher rates of recovery, quality of life, and meaning of life (Kaplan et al., 2012).

Whisman and Baucom (2012) explored the associations between relationship functioning and individual mental health and well-being. The researchers found that discord in relationships does not improve with individual-based treatments

for psychopathology and couple-based interventions in the treatment for mental disorders may have more efficacy with attention to substance-related, mood, and anxiety disorders (Whisman & Baucom, 2012). Black et al. (2013) assessed the role of shame coping styles and the state of shame in estimating the therapeutic alliance and couple relationship functioning in individuals with psychiatric illness. Results revealed that the shame coping strategy of psychological and physical withdrawal was the main risk factor for a less efficacious therapeutic alliance development (Black et al., 2013). Both attack self-coping styles and withdrawal were important predictors of impaired intimate relationship functioning (Black et al., 2013). The findings of this study are important to the theoretical role of shame in mental health presentations as well as the capacity for internalizing shame coping styles acting as a barricade to successful therapy and interpersonal relationships (Black et al., 2013).

Disclosure of Bipolar Disorder in Relationships

According to the CDC (2016), only 25% of adults surveyed with mental illness believe that people are sympathetic and caring to persons with mental health symptoms. The CDC found that three quarters (75%) of people surveyed who were living with a mental health problem reported that they would fear telling their partner about their illness for the first time (CDC, 2016). One in ten people surveyed with a mental illness said it took them over a year to finally disclose to a new partner about their psychiatric disorder (CDC, 2016). Individuals experiencing bipolar disorder may be scared to confide in others about their symptoms because of social stigma (Seeman, 2013). Seeman (2013) aimed to develop disclosure guidelines for individuals in

relationships experiencing mental illness. An electronic search was conducted on the stigma, communication, secrecy, sociology, and matchmaking literature that pertained to psychiatric conditions (Seeman, 2013). The conclusion was that pre-existing mental illness must be disclosed to prospective marriage partners once these partners have established trustworthiness (Seeman, 2013). The recommendation is that disclosure occur in stages with continuous discussion and that there should be attempts to address all relevant partner concerns and issues (Seeman, 2013). Although a psychiatric condition does not define an individual; the diagnosis and its implications are of importance and should be disclosed to prospective marriage partners (Seeman, 2013).

African Americans, Mental Illness, and Relationships

Scientists have directed some attention to the existence of racial-ethnic disparities in both quality of and access to mental health care services for African Americans with psychiatric disorders (Johnson et al., 2009; Barr et al., 2013; Johnson & Johnson, 2014). The needs of many African Americans are not addressed in current psychiatric disorder evaluation and treatment paradigms (Johnson et al., 2009). The limitations that African Americans experience in social and health-care systems and treatment responses needs to be further researched. Johnson et al. (2009) studied low-income African American women with panic disorder. The women participated in a series of focus-group sessions that elicited perspectives regarding access and treatment barriers and recommendations for creating treatment programs that are culturally consistent (Johnson et al., 2009). Results indicated that fear of confiding in others about symptoms, distress over social stigma, and a lack of knowledge about the

disorder were major individual barriers (Johnson et al., 2009). Within their social networks, stigmatizing attitudes toward psychiatric disorders, discouragement about using psychiatric medication, and the perception that symptoms are caused by personal or spiritual weakness all interfered with the women's efforts to seek treatment and contributed to a common experience of severe social isolation (Johnson et al., 2009). None of the participants developed fully effective therapeutic relationships with treatment providers (Johnson et al., 2009). The focus group members asserted an unmet need for more culturally authentic and interactive relationships with mental health and medical providers (Johnson et al., 2009).

Given persistent racial disparities across health and relationships, findings in a study by Barr et al. (2013) proved practically and theoretically significant. Barr et al. (2013) found that there is substantial instability in both romantic relationship presence and quality during the transition into adulthood (Barr et al., 2013). Particular instability patterns are uniquely correlated with changes in mental and physical health (Barr et al., 2013). There needs to be further clarity on the source of racial disparity where issues influencing this disparity may be unique to bipolar disorder (Johnson & Johnson, 2014). Generally, among African Americans, poor care for bipolar disorder may be accentuated (Johnson & Johnson, 2014). African Americans are vulnerable especially to inaccurate evaluation of symptomology and receive a misdiagnosis of schizophrenia more often than individuals in other groups (Johnson & Johnson, 2014). Even if there is an accurate diagnosis, African Americans are less likely to receive treatment as intensive as whites or more likely to receive inadequate treatment (Johnson & Johnson, 2014). Johnson and

Johnson (2014) assessed disparity in bipolar disorder treatment for African Americans and and white Americans. Blacks were found to be less likely than whites to have used mood stabilizers in the previous year (Johnson & Johnson, 2014). The disparities were not explained by sociodemographic characteristics, service use, and symptomology expression (Johnson & Johnson, 2014). The study concluded that there is substantial racial inequality in the treatment of bipolar disorder (Johnson & Johnson, 2014).

African Americans and Relationships

The divorce rate for African Americans currently stands at 12 percent. This is in comparison to the 10 percent of white couples who divorce each year and 7 percent of Hispanic couples (Chambers & Kravitz, 2011). Furthermore, the marriage rate is lowest among African Americans than any other racial and ethnic group in the United States (Chambers & Kravitz, 2011). Structural barriers that lead to low marriage rates among African Americans and important policy implications have been documented (Chambers & Kravitz, 2011). However, researchers have not sufficiently explored the interpersonal and psychological constraints to couple-hood among African Americans (Chambers & Kravitz, 2011). Simons, Simons, Lei, and Landor (2012) asserted that adverse circumstances African American youth experience disproportionately including discrimination, criminal victimization, financial hardship, and family instability contribute to distrustful relational schemas and troubled dating relationships. In turn, these negative relationship experiences encourage a less positive view of marriage.

The black-white marriage gap involves labor market disparities and other structural disadvantages experienced by African Americans (Raley, Sweeney, & Wondra,

2015). The affordability of marriage and imbalances in the numbers of men and women available for marriage are classic arguments for the gap in marriage for African Americans compared to whites (Raley, Sweeney, & Wondra, 2015). These arguments link lower marriage rates among black women to a shortage of marriageable men and tend to focus on differences in men's employment prospects and incarceration (Raley, Sweeney, & Wondra, 2015). The scarcity of well to do black men relative to black women, which is compounded by black men's relatively lower levels of education and higher rates of interracial marriage, may increase black men's bargaining power and make marriage less attractive to them as an option in early adulthood (Raley, Sweeney, & Wondra, 2015). This argument assumes that men would rather have informal relationships with women than marry, despite having access to a larger pool of women eligible for marriage (Raley, Sweeney, & Wondra, 2015).

African American Marriage and Mature Love Relationships

Curran, Utley, and Muraco (2010) explored what marriage meant to African Americans. Love and commitment were the two major themes that emerged (Curran, Utley, & Muraco, 2010). Other themes that emerged less frequently included friendship/partnership, family, trust, and covenant (Curran, Utley, & Muraco, 2010). Overall, the meaning of marriage was positive, with only a few negative exceptions such as marriage as unfulfilling or unnecessary. Tyson (2011) explored perspectives of emerging adult African American women on mature love relationships development. The Tyson (2011) study yielded themes related to relationship goals and characteristics, as well as interpersonal and societal challenges to acquiring the right partner,

and maintaining a mature love relationship (Tyson, 2011). Tyson (2011) explained the impact of historic and contemporary interpersonal and societal factors on existence and ethnic challenges to positive gender identity development, the hastening of intimacy and maturity, and hindrance of mature love relationship development among African American women (Tyson, 2011).

African American Committed Relationships and Cohabitation

A study by Chaney, Mitchell, and Barker (2014) suggested that African American cohabiters had slightly more intimacy problems than counter parts of other races. The same study asserts that there were no significant differences in commitment or satisfaction between engaged and non-engaged African American cohabiters. Additional analyses revealed no variation in the impact of engagement on relationship quality by gender (Chaney, Mitchell, and Barker (2014). Chaney (2014) investigated how African Americans who are cohabiting and married experience and define commitment and emotional closeness because extant research has shown a direct link in these processes to relationship stability. The themes elicited from these interviews in the Chaney (2014) study, garnered special attention as they illuminated the particular ways in which married and cohabiting African American couples regarded commitment and emotional closeness (Chaney, 2014). There were few apparent differences in perceptions of emotional closeness (Chaney, 2014). However, married couples were more likely to report that commitment played a major role in their decision to be together (Chaney, 2014). Conversely, the views expressed about commitment were different for cohabiting couples where the role of commitment was minimal in their relationship or commitment was

experienced in ways that were not linked to the relationship's legal affirmation (Chaney, 2014).

The Role of Religion/Spirituality in African American Relationships

Several studies asserted that African American attitudes and perspectives on marriage are often shaped by religion (Phillips, Wilmoth, Marks, Loren, 2012; Hurt, 2014; Collins, Wanda, Perry, Armon, 2016). The black church plays a role in facilitating healthy marriages and family stability (Collins, Wanda, Perry, Armon, 2016). African Americans' religiosity resulted in them equating marriage with robust and stable families. This was the driving factor behind mate selection, and molded their behavior within relationships and marriage (Collins, Wanda, Perry, Armon, 2016). For many African Americans, the black church was uniquely positioned to advance marriage and family stability through vigorous and targeted outreach, healthy relationship paradigms, mentoring programs, and plenty of access to pre-marital counseling (Collins, Wanda, Perry, Armon, 2016). Vaterlaus, Skogrand, and Chaney (2015) probed study participants about what resources they would seek if marital issues arose, gender differences in the willingness to seek professional help for marital issues, and their lived experience with seeking help for marital issues. The study by Vaterlaus, Skogrand, and Chaney (2015) revealed that African Americans most frequently cited religion/spirituality and family (immediate/extended) as resources for help when experiencing marital problems. The study did not uncover any significant difference between men and women in their willingness to seek professional help for marital challenges (Vaterlaus, Skogrand, & Chaney, 2015). When discussing help-seeking experiences for challenges in marriage,

participants revealed that they contemplated the trustworthiness of the resource, customarily relied on religion/spirituality, and preferred to handle their issues within the context of their relationship (Vaterlaus, Skogrand, & Chaney, 2015). Thus religion and spirituality play a major role in relationships as it does in coping with mental illness (Vaterlaus, Skogrand, & Chaney, 2015; Marks, Tanner, Nesteruk, Chaney, Baumgartner, 2012).

Challenges to Stability of African American Relationships

The formation of African American relationships is significant because changes in family formation have crucial implications for the life chances of children, the well being of individuals, the involvement of parents, and the stability of the family (Perry, 2013). Race has an impact on African Americans' access to traditional models of family formation. Stereotypes about race are rampant and leave traces of observable damage in unwitting victims (Perry, 2013). Furthermore, in order to enhance stability of African Americans' relationships, societal circumstances that restrict opportunities for education and income and diminish relationship bonds must be changed (Cutrona, Russell, Burzette, Wesner, Bryant, Chalandra (2011). The aforementioned studies are relevant to the current dissertation because they also discuss premature responsibility, especially early caregiver burden that can occur in some relationships (Tyson, 2011). To be protected, and to have someone to help carry the weight was a significant factor to the respondents in a study by Tyson (2011) which could be complicated if a partner is experiencing bipolar disorder. A primary challenge of respondents in this study was to counteract negative stereotypical images, so that they could foster their own self-

identities as women and as partners in a relationship (Tyson, 2011). Future research and practice implications include the significance of highlighting the individual and cultural deterrents that impact the relationship stability of African American couples that are low income (Chaney, 2014).

Summary

Bipolar disorder is the sixth most common disability in the United States (Johnson & Johnson, 2014). Bipolar Disorder is a psychiatric disorder marked by alternating periods of depression and elation (NAMI, 2016). Recovery from a bipolar episode is geared toward making sure individuals suffering from the illness lead meaningful lives in their community (Tse, Murray, Chung, Davidson, Ng, & Yu, 2014). Extant research has demonstrated that bipolar disorder impacts social relationships such as marriage and other intimate relationships in a negative way (Whisman et al., 2014). The quality of relationships involving a partner experiencing bipolar disorder is often poorer (Sheets & Miller, 2010). Interpersonal dysfunction for individuals with bipolar disorder is often related to stigma about the illness (Oliveira, Esteves, & Carvalho, 2015). Disclosing one's mental health status to a partner is often difficult because of fear of stigma (Seeman, 2013). Age and the inauthenticity of a relationship also influence relationship outcomes for couples where at least one partner is experiencing bipolar disorder (Soller, 2014). However, social activities such as dating and being in relationships enhance management of bipolar disorder (Kaplan et al., 2012). Research has directed attention to racial-ethnic disparities that exist in both access to and quality of mental health services for African Americans with psychiatric disorders (Johnson, Mills, DeLeon, Hartzema, &

Haddad, 2009; Barr et al., 2013; Johnson & Johnson, 2014). African Americans are especially vulnerable to inaccurate evaluation of symptomology and experience a misdiagnosis of schizophrenia more than individuals in other populations (Johnson & Johnson, 2014). Even if there is an accurate diagnosis, African Americans are less likely to experience as intensive treatment as whites (Johnson & Johnson, 2014). Within social networks, stigmatizing attitudes toward mental illness, discouragement about the using psychiatric medication, and the perception that symptoms result from personal or spiritual weakness all interfere with treatment seeking efforts and contributed to a common experience of severe social isolation (Johnson, Mills, DeLeon, Hartzema, & Haddad, 2009). In order for treatment of mental illness to be effective for African Americans it must take a culturally relevant approach (Parks, 2016).

Patterns of relationship instability are uniquely correlated with changes in mental health (Barr et al., 2013). However, the repression of relational needs can lead to symptoms of mental illness (Javdani, Rodriguez, Nichols, Emerson, & Donenberg, 2014). For African Americans and other demographic groups, a sense of belongingness can reduce symptoms of mental illness and suicide ideation (Hollingsworth, Wingate, Tucker, O'Keefe, & Cole, 2016). Despite the presence of mental illness African Americans tend to take a 'for better or for worse' approach to relationships (Lei, Beach, Simons, Barr et al., 2016). Research also shows that many African Americans have positive coping strategies for relationship ills and stressful situations like racial discrimination (Powell, Banks, & Mattis, 2016). Spirituality is a salient coping mechanism for mental illness and stressful situations such as racial discrimination and relationship dysfunction (Staton-

Tindall, Duvall, Stevens-Watkins, & Oser, 2013).

In the African American community, commitment plays a role in if a couple decides to be together (Chaney, 2014). Having someone to help share the burden is also important to African American relationships (Tyson, 2011). African Americans often seek a partner who has characteristics similar to their parents and model their relationships after their parents (Allen & Mitchell, 2015). Honesty, respect, trust, good communication, understanding, compromise, self-confidence, and individuality are qualities admired in a partner among African Americans (Debnam, Howard, & Garza, 2014). In the African American community, spirituality and religion are he most sought resources for marital and relationship help (Vaterlaus, Skogrand, & Chaney, 2015). A core challenge for African Americans is to counteract negative stereotypic images, so that they can foster their own self-identities as people and as partners in a relationship (Tyson, 2011). Countering negative stereotypical images coupled with a mental illness diagnosis intensifies relationship functioning for African American couples (Tyson, 2011).

Conclusion

This study is significant because it fills a gap in the existing literature regarding the specifics of bipolar disorder and how it affects relationship acquisition and maintenance specifically within the African American community. This study may contribute to a body of existing literature on mental health and relationships. Furthermore, this study may promote learning and understanding about bipolar disorder and the impact of mental illness on relationships (Whitton et al., 2013). The literature reviewed has addressed how involvement in a committed relationship is correlated with

less problematic substance use and fewer depressive symptoms in individuals with bipolar disorder (Whitton et al., 2013). The suppression of relational needs can result in an increase in psychiatric symptoms while relationships can serve as a buffer against psychiatric symptoms (Javdani, Rodriguez, Nichols, Emerson, & Donenberg, 2014; Townley, Miller, Kloos, 2013)

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the experiences, attitudes, and perceptions of African American adults who are in relationships with individuals suffering from bipolar disorder. This was a generic qualitative study. In generic qualitative study, researchers explore an individual or small group, drawing conclusions only about that participant or participant pool and only in that context (Prech et al., 2015). Researchers do not focus on the discovery of a generalizable, universal truth, nor do they typically look for cause-effect relationships. Emphasis is instead placed on exploration and description (Starnino, 2016). Typically, the data collection process involves a variety of methods. Some common methods include interviews, field studies, protocol analyses, and participant-observations to garner descriptions of major social trends (Starnino, 2016). Through an examination and discussion of various cases, researchers can recognize actual problems, identify key players and their agendas, and become aware of those aspects of the situation that contribute to the problem (Starnino, 2016).

Research Question

How do adults in the African American community experience relationship acquisition and maintenance with a partner who has been diagnosed with bipolar disorder?

Research Design and Rationale

In this study I took a qualitative approach to exploring the experiences of African American adults including the needs, challenges, and misunderstandings they have been

subjected to while in relationships with individuals experiencing bipolar disorder. A qualitative research study often takes place in a natural setting, and the researcher acts as the instrument (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017). Sampling for a qualitative study involves purposefully selecting participants who help with illuminating an understanding of the research problem rather than random sampling used in quantitative studies (Levitt et al., 2017). Scholars use a qualitative methodology when they need to explain links or mechanisms that cause things (Levitt et al., 2017). Furthermore, a rationale for qualitative research is that measures often do not fit the problem well (Levitt et al., 2017). Where many interactions can be hard to quantify, observing participants in their struggles and probing the source of the problems help define what needs to be measured (Levitt et al., 2017). For this study, qualitative data can help uncover the right things to measure (Levitt et al., 2017).

This study was a generic qualitative rather than an ethnography because it focused studies on the socio-cultural instead of simply the culture of a group. This study was not a case study because it focused on the sum of experiences of individuals versus that of a single case. Unlike grounded theory, generic studies focus on deriving themes from the experiences of individuals rather than developing a theory of explanation. Lastly, this study was not a phenomenology, although closely related, this study focused on the "what" of an experience, while phenomenology focuses on the "how" within an experience (Starnino, 2016).

Instead of multiple forms of data collection, I used a linear approach and offered robust analytical conclusions (Gustafsson, 2017). Multiple case studies can be used to

either argue contrasting results for expected reasons or to argue similar results across the studies (Gustafsson, 2017). With this approach, I was able clarify whether the findings are valuable or not (Gustafsson, 2017). Evidence created from a generic qualitative study can be measured as strong and reliable when compared to evidence in the literature (Gustafsson, 2017). Another advantage is that the theory becomes more convincing (Gustafsson, 2017. Analyzing a generic qualitative study also permits a wider exploration of the research question and greater theoretical evolution (Gustafsson, 2017).

Role of the Researcher

The researcher is considered the instrument of data collection (Granek & Nakash, 2016). The data are mediated through a human instrument, rather than through questionnaires, inventories, or machines (Granek & Nakash, 2016). To clarify my identity to the participants, it helps to self-identify using such markers as gender, race, ethnicity, and socioeconomic status (Granek & Nakash, 2016). I am an African American middle-class woman. Depending upon the purpose of the study and the population under study, it may be useful to identify oneself culturally and linguistically, as well as acknowledge the levels of privilege and power conferred by such status (Granek & Nakash, 2016). Naming the degree of insider/outsider status means detailing the amount of experience, or lack thereof, the researcher has with the target population (Granek & Nakash, 2016). I was diagnosed with bipolar disorder in 2004, but later the doctor retracted the diagnosis. During the time in which I carried the diagnosis, I found it difficult to disclose my mental health status to potential partners. This experience makes me somewhat of an insider. I continue to moderate mental health discussion groups for

individuals experiencing mental illness and their caregivers. The aforementioned events drew me to this topic along with my long-time interest in fortifying relationships within the African American community.

My insider status, however, can create bias. It can be argued that a lot of these problems are due to the researcher's role in the research process as he/she is personally involved in every step taken. Thus, I controlled for bias through personal reflexivity, member checking, and member triangulation known as bracketing (Granek & Nakash, 2016). Bracketing is the method used in qualitative research to mitigate the potentially deleterious effects of preconceptions that may taint the research process (Granek & Nakash, 2016). However, the processes through which bracketing takes place are poorly understood; thus, I will elaborate on personal reflexivity, member checking, and member triangulation (Granek & Nakash, 2016). Personal reflexivity involves situating my knowledge as a researcher within relevant contexts, whether interpersonal, institutional or cultural (Granek & Nakash, 2016). Member checking occurs when interpretations and conclusions are tested with members of those groups from whom the data were originally obtained (Granek & Nakash, 2016). Member triangulation will take place when I collect data from more than one member of the group I am studying (Granek & Nakash, 2016). Bracketing is presented as engagement with the data and the evolving findings (Granek & Nakash, 2016).

The precision with which I identify myself reveals the lens and the degree of sensitivity with which I collected, viewed, analyzed, and reported the data (Granek & Nakash, 2016). In the case of conducting research with participants who differ from me

culturally or linguistically, this information signals to the reader that care has been taken to acknowledge the distance between the lived experiences of the student and those studied (Granek & Nakash, 2016). This impacts the decisions I make at each stage of the research, such as, selecting samples, structuring interview questions, conducting observations, identifying themes within the data, and creating meaning behind those themes (Granek & Nakash, 2016).

Methodology

Qualitative researchers use inductive reasoning, which is the organization of themes from the bottom up until a comprehensive set of themes is established (Madill & Gough, 2016). Qualitative researchers build on inductive, rather than deductive reasoning. It is from the observational elements that pose questions that the researcher attempts to clarify established (Madill & Gough, 2016). Inductive reasoning is used to expand upon the typology (Madill & Gough, 2016). Furthermore, I implored the qualitative component of reflexivity (Madill & Gough, 2016; Johnson, 2016). I focused on participants' perspectives regarding their experiences dating individuals diagnosed with bipolar disorder. In this case, the entity was African American adults aged 21-45 who have dated or been in a relationship with an individual diagnosed bipolar disorder in the last 5 years. To present an in depth understanding of the cases, I collected many forms of data such as interview responses and data from research articles (Levitt, 2016).

Participants and Sampling Strategy

For this study, I used purposeful sampling (Wahlstrom, 2017). I will have a sample of 10-12 participants. The number of participants is based on the concept of

saturation, which typically limits the sample to this range (Wahlstrom, 2017). Purposeful sampling involves selecting cases rich with information from which a researcher can learn in-depth information about the central issue (Wahlstrom, 2017). Purposeful sampling leads to in-depth insights rather than the empirical generalizations yielded in quantitative research (Wahlstrom, 2017). Purposeful sampling is comparison-focused sampling. For example, I compared responses by gender in the analysis (Read, 2016). I can adjust the sample as the inquiry deepens (Levitt, 2016). There are many strategic options for qualitative method studies (Wahlstrom, 2017). The range of experiences covered will also be moderate (Johnson, 2016). Data for this project were derived from semistructured, open-ended interviews with African American adults. The sampling frame consist of African American adults, aged 21-55. Respondents had dated or been in a relationship with an individual diagnosed with bipolar disorder within the last 5 years. Dating was defined as romantic involvement with an individual for at least 3 consecutive months and did not have to be exclusive. The definition of relationship in this study referred to engagements that are exclusive, lasted at least 3 consecutive months, and may be ongoing.

Respondents were interviewed in person in a private room at Montgomery County Virginia public library. I obtained permission to record the conversations. I solicited participation via flyers (Appendix D) that I posted on local university campuses, social service agency offices, mental health support centers, parks and recreation centers, and health department bulletin boards. I had letters of agreement (Appendix C) from each of the places I was soliciting participants.

Instrumentation

This study involved coding interviews, documents, and observation logs to indicate the typology (Hyett et al., 2014; Johnson, 2016). This study consisted of a detailed and rigorous approach to data collection as seen in qualitative research (Hyett et al., 2014). As the researcher, I was the key instrument in this study (Hyett et al., 2014). As the key instrument, I collected the data, observed the behavior, examined the documents, and interviewed the participants (Hyett et al., 2014). To control for bias, I used member checking to ensure my interpretations are representative of the participants' beliefs (Hyett et al., 2014). Another method I used to control for bias was to verify information with more data sources or triangulate data sources such as the interviews and observations and support my interpretations and increase confidence that what I have found was legitimate (Hyett et al., 2014). I also checked for alternative explanations to control for bias (Hyett et al., 2014). I considered whether there are other reasons why I drew the interpretations that I did (Hyett et al., 2014). If I can rule out or account for alternative explanations, my interpretations will be stronger (Hyett et al., 2014; Johnson, 2016).

Data Collection Techniques

Interviews were conducted in person. I ensured anonymity and confidentiality by assigning the participants' date of birth and last four digits of their phone number as pseudonyms, and I separated any of the respondents' identifying information from the interview responses. The semistructured interview are a combined approach of an informal conversation interview and a standardized open-ended interview (Precht et al.,

2015). I combined these data collection techniques by starting out with standardized open-ended questions and leaving room for probes (Precht et al., 2015). I asked the interviewee to provide demographic information during screening questions such as gender and race (Precht et al., 2015). I documented verbal and nonverbal ques as well as took note of the interviewee's emotions and behaviors with the face-to-face interview technique (Precht et al., 2015). As a thank you for participating, I gifted each participant a 15-dollar Target gift card for his or her time. The gift card was not be provided until the interview was complete.

Data Management and Analysis Techniques

Various data analysis techniques complement one another by drawing out patterns from concepts and insights (Starnino, 2016). One data analysis strategy I used was sketching ideas (Starnino, 2016). In the sketching ideas process, I made margin notes in the field notes I took from the interviews (Starnino, 2016). I then highlighted certain information. Another data analysis strategy I used was to summarize the field notes I took from the interviews (Starnino, 2016). I also identified codes and reduced codes to themes (Precht et al., 2015). This involved identifying salient themes and patterns or making notes of identified pattern regularities (Precht et al., 2015). I also used the data analysis strategy of counting the frequency of codes and relating categories (Starnino, 2016). This allowed me to build a logical chain of evidence (Precht et al., 2015).

Data Management

I began analysis during data collection by noting and recording emergent patterns and possible themes (Johnson, 2016; Starnino, 2016). It is important for me as an

investigator to take an inventory of the data and make sure data elements and sources are labeled, dated, and complete (Johnson, 2016; Starnino, 2016). Filling in the gaps of the data as soon as possible is also an important data management technique that I used (Johnson, 2016; Starnino, 2016). I protected data by backing it up on a drive and making sure it is secure by taking steps to ensure anonymity and confidentiality (Johnson, 2016; Precht et al., 2015). I used individual birth dates as pseudonyms for respondents, and I separated any of the respondents' identifying information from the interview responses. I used NVivo software to organize the data by themes (Johsnon, 2016). Videos and articles used in triangulation to verify my interpretations along with interviews were all uploaded into NVivo for analysis (Johnson, 2016). As the investigator, I kept an analysis journal and determine the analysis strategy (Johnson, 2016; Precht et al., 2015). I also organized data in charts and matrices for analysis (Johnson, 2016; Precht et al., 2015).

Data Interpretation

For this study, I sought to illuminate emergent themes about the barriers to social activities such as dating and relationships for individuals experiencing mental illness in the African American community. While interpreting the data, I became familiar with the data through reading and creating memos (Gerring & Cojocaru, 2016). I examined the data in depth to provide detailed descriptions of the setting, participants, and interview activities (Gerring & Cojocaru, 2016). Data interpretation also consisted of categorizing and coding pieces of data and grouping them into themes (Gerring & Cojocaru, 2016). Interpreting the data involves describing or developing comprehensive descriptions of settings or participants (Gerring & Cojocaru, 2016). Classifying, which

involves breaking data into analytic units, categories, and themes is another component of data interpretation I used (Gerring & Cojocaru, 2016). When identifying themes, I began with the big picture and listed themes that emerge (Aaboen, Dubois, & Lind, 2012). When I coded the qualitative data, it was important that I reduce data to a manageable form (Aaboen et al., 2012). I did this by writing notes on note cards and sorting them into themes (Aaboen et al., 2012). Interpretation of data depends on the perspective of the researcher (Aaboen et al., 2012). I extended the analysis by raising questions, connecting findings to my personal experiences, seeking the advice of my critical friends, contextualizing findings in the research, converging evidence, and turning to theory (Aaboen et al., 2012).

Verification of Trustworthiness/Authenticity

I emphasized trustworthiness, authenticity, and transferability in this study through prolonged engagement, persistent observations, triangulation, member checking, and self-reflection (Mertens, 2017). I used authenticity criteria for determining the goodness, reliability, validity, and rigor of the research (Mertens, 2017). Trustworthiness is the extent to which I can have confidence in the study's findings (Mertens, 2017). Trustworthiness is parallel to reliability, validity, and objectivity in traditional quantitative research (Mertens, 2017). Transferability is applicability of findings based on comparability of contexts (Mertens, 2017).

Establishing Credibility and Reliability

To ensure creditability or internal validity, I used persistent observation (Yardley, 2017). This technique involves continuing the data collection process to permit

identification and assessment of salient factors and investigation in sufficient detail to separate relevant or typical from irrelevant or atypical (Yardley, 2017). Findings and interpretations are plausible to the researched participant and accurately reflect the participant's reality (Mertens, 2017). Member checking is another technique that I used to ensure creditability to test the veracity of the data, analytic categories (e.g., codes), interpretations, and conclusions with stakeholders to ensure accurate representation of perspectives (Mertens, 2017). Referential adequacy or the archiving of a portion of the raw data for subsequent analysis and interpretation, for verification of initial findings and conclusions is another source of internal validation that I will employ (Mertens, 2017). I used thick description or describing procedures, context, and participants in sufficient detail to permit judgment by others of the similarity to potential application sites; I specified minimum elements necessary to recreate findings to ensure transferability or external validity (Mertens, 2017). I then employed reflexive journaling using my personal notes (Mertens, 2017). I used different types of questions and different ways of interviewing, although all the interview questions were open ended. A barrier to validity and reliability in the sampling is that I cannot make generalizations from such a small sample (Yardley, 2017). However, I can discuss what the group has in common (Yardley, 2017).

Validity Threats

There can be threats to descriptive validity (Yardley, 2017). What I am unable to record while gathering data is often as significant as what is collected (Yardley, 2017). As the researcher, I will record and transcribe interviews completely and accurately

(Yardley, 2017). I will make sure that the words and phrases documented are those of the person being observed (Yardley, 2017). Tape recordings of interviews can help verify descriptive data but will not be able to eliminate all of the threats (Yardley, 2017). As the researcher, I will describe the environment and actions that are not captured by the tape recordings to guarantee all the causes of what occurred could be captured and examined (Yardley, 2017).

There can also be threats to interpretation validity (Yardley, 2017). To effectively interpret activity, I will capture the observation as interpreted by the individual being researched (Yardley, 2017). The primary threat to valid interpretation is imposing my own meaning, instead of understanding the viewpoint of the individuals being studied and the meanings they attach to their words, phrases and actions (Yardley, 2017). To avoid compromising interpretation validity, I will ask open-ended questions, as well as follow up questions which will allow the respondent to elaborate on answers. Inquiries should not be confusing or directional to obtain any response other than the one the participant would have normally given (Yardley, 2017).

Researcher bias is another validity threat. Each and every researcher will have some kind of bias (Yardley, 2017). As the investigator I will determine and be aware of my personal biases through self-reflection, to make sure that they do not influence the outcome of the study (Yardley, 2017). Some techniques I will use are: re-phrasing questions for different individuals, and asking leading questions (Yardley, 2017). These techniques can reduce response bias or influence over the participant's responses. Threats to theory validity may occur as well. In the beginning of an investigation, the

researcher usually has a specific viewpoint or theory that he or she feels the data will support (Yardley, 2017). I will need to ensure that I do not force the data to match a particular theory, nor can ignore data that does not suit the theory (discrepant data) (Yardley, 2017).

Potential Conflicts and Biases

One potential conflict or bias of this study is that intense exposure to the cases of study could bias the findings (Fletcher, 2017). Another potential conflict and bias comes from my experience as an insider. Though the diagnosis was later retracted, having been diagnosed with bipolar disorder at one time and being a proctor of mental health support groups affords me some insight into the hierarchy and politics of the institution of mental health. Unconsciously making wrong assumptions about the research process based on my prior knowledge can be considered a bias. Through awareness and self-reflection, I will attempt to overcome these conflicts and biases (Fletcher, 2017).

Ethical Considerations

It is important for social science research to address marginalized and disadvantaged groups to bring about change for those populations (Oye et al., 2016). Although a vulnerable population such as individuals with mental illness are not the subjects of this study and the focus is rather on participants' attitudes and beliefs about relationships with individuals experiencing mental illness, measures of informed consent will still have to take place in order to ensure their privacy and confidentiality are not violated (Oye et al., 2016). Pseudonyms will be used to ensure the respondents anonymity and confidentiality (Oye et al., 2016). Measures of informed consent will

involve individuals signing a form explaining the study and the option to withdraw at any time (Oye et al., 2016). A copy of the informed consent form can be found in the appendices.

Additional Ethical Procedures

As a researcher conducting qualitative research, I have an immense responsibility (Oye et al., 2016). Should participants desire follow up counseling resources I will provide them with a hotline number to ACCESS community services available to anyone who needs counseling. Arrangements have been made with ACCESS counselors to handle calls from participants of this study. As there is no statistical analysis in qualitative research, I must both evaluate what I observe and interpret it (Oye et al., 2016). As a researcher, I should possess the necessary skills to lead to optimal extraction of reliable data from qualitative research (Oye et al., 2016). Also, as a researcher, I face ethical challenges in all stages of the research, from designing to reporting. These include ensuring anonymity, confidentiality, and informed consent, researchers' potential influence on the respondents and vice versa (Oye et al., 2016). It is of paramount importance that I be well informed of all the different aspects of my roles when acting as a qualitative researcher (Oye et al., 2016). Hence, I will define these adroit roles and the use of practical guidelines and protocols in all stages of qualitative studies should be encouraged (Oye et al., 2016). As a researcher, I will provide information to my participants regarding the procedures so that the participants may decide to participate in the study (Anderson, Leahy, DelValle, Sherman, & Tansey, 2014). As a researcher, I must disclose information, including the expected benefits and risks, and the likelihood

(or probability) that the benefits and risks will occur (Anderson, Leahy, DelValle, Sherman, & Tansey, 2014).

Summary of Research Design

This current generic qualitative study research seeks to explore the attitudes and perceptions of African American adults involved in dating and relationships with individuals experiencing bipolar disorder. The current qualitative study seeks to illuminate emergent themes regarding the barriers to social activities such as dating in relationships for individuals experiencing mental illness in the African American community. This study contributes to social change as it may open up discussions about experiences, attitudes, and perceptions surrounding a vulnerable population. This subject has been underwritten and this study will promote social change as participant's perspectives are validated. The data collection techniques most appropriate for the current qualitative research plan are interviews. I will analyze data from 10-12 interviews. Participants must be African American, between the ages of 21-55, and have experience with dating and relationships with individuals experiencing bipolar disorder within the past 5 years. Dating is defined as a non exclusive romantic engagement that lasted at least 3 consecutive months and relationships are prolonged exclusive romantic engagements.

Chapter 4: Results

Introduction

The purpose of this study was to examine the attitudes and perceptions of African American men and women regarding their experiences in a dating relationship with an individual who has been diagnosed with bipolar disorder. I used a generic qualitative study approach using data gathered from in-depth interviews with African American adults. The research question which guided this study was as follows:

How do African American adults experience relationship acquisition and maintenance with a partner who has been diagnosed with bipolar disorder?

In Chapter 4, demographic details of the participants, the setting, and the data collection methods are provided. The analysis process moved inductively from coded units to significant themes that emerged from the data. Strategies used to ensure credibility, confirmability, dependability, and transferability are described. A summary of major findings as they relate to the research question concludes Chapter 4.

Setting

All data collection took place over private Facebook and Facetime video chat. The participants were offered a choice of in-person or video chat for the in-depth interviews. The first option was the use of a private room at a public library. However, due to differences in geographic location, all of the participants chose to conduct interviews via video chat. No conditions such as physical illness or emotional distress were reported as inhibiting the respondents' participation in the study.

Demographics

This study was conducted with African American adults between the ages of 24 and 47, from all over the United States. Basic and relevant demographic detail is provided to enable a sense of the participant group. Explicit personal details were withheld to protect the confidentiality of the participants. Twelve African American adults were interviewed separately. The group consisted of three female participants and nine male participants. Each of the 12 participants confirmed inclusion criteria prior to engagement in the study.

Participant Demographics

Demographic details of the 12 participants are provided in Table 1.

Table 1.

Demographics

Participant Number	Age	Marital Status	Current Relationship Status	Sexual Identity	Length of time in relationship of interest	Gender identification
1	47	Divorced	Single	Heterosexual	6 months	Male
2	27	Never married	In a relationship	Heterosexual	9 month	Male
3	41	Never married	Single	Heterosexual	11months	Male
4	37	Never married	In a relationship	Heterosexual	5 months	Male
5	45	Divorced	Single	Heterosexual	13 years	Female
6	33	Never married	In a relationship	Heterosexual	8 months	Male
7	38	Divorced	Single	Heterosexual	10 years	Male
8	38	Never married	Single	Heterosexual	7 years	Male
9	29	Never married	In a relationship	Heterosexual	4 years	Male
10	24	Never married	In a relationship	Heterosexual	1 year and 3 months	Female
11	29	Never married	In a relationship	Heterosexual	2 years	Male
12	39	Divorced	Single	Heterosexual	1 year	Female

Summary of Demographics

All of the participants indicated that they were no longer in the relationship of interest. Twelve African American adults who had previously dated or been in a relationship with an individual diagnosed with bipolar disorder were interviewed for this generic qualitative study. Each of the participants were 18 years or older and had dated or been in a relationship with an individual diagnosed with bipolar disorder for at least 3 months. Demographic detail provides background information and confirms the identifying criteria whilst protecting the confidentiality of the participants. Each of the participants indicated that they were heterosexual. Participant 1 was a 47-year-old male, divorced, and currently single. Participant 2 was a 27-year-old male, never married, and currently in a relationship with a female. Participant 3 was a 41-year-old male who had never been married and was currently single. Participant 4 was a 37-year-old male who had never been married and was currently in a relationship. Participant 5 was a 45-year-old female, divorced, and currently single. Participant 6 was a 33-year-old male who had never been married and was currently in a relationship. Participant 7 was a 38-year-old female, divorced, and currently single. Participant 8 was a 38-year-old male, never married, and currently single. Participant 9 was a 29-year-old male who had never been married and was currently in a relationship. Participant 10 was a 24-year-old female who had never been married and was currently in a relationship. Participant 11 was a 29-year-old male, never married, and currently in a relationship. Participant 12 was a 39-year-old male who was divorced and currently single.

Data Collection

As the primary instrument in data collection and analysis, I attempted to set aside, or bracket, personal experiences as they relate to the topic. Granek and Nakash (2016) acknowledged the difficulty in setting aside all previous habits of thought. I recorded personal experiences and feelings associated with dating individuals diagnosed with bipolar disorder to reduce any bias and fully explore the experiences of the participants.

Each participant signed, scanned, and returned an informed consent prior to the interview. The consent form included the title and summary of the study along with contact information and the institutional review board approval number with its expiration date. Some examples of potential interview questions were included in the consent form. Additionally, the consent letter outlined the eligibility criteria for the study and was signed by each of the participants prior to each interview.

Following verification of inclusion criteria, the location and time of the interview were scheduled. Semistructured interviews were conducted using protocol with standardized probes. Probes and follow-up questions were used to elicit and gather rich and detailed descriptions. A copy of the interview guide can be found in Appendix A. Gift cards were presented to participants after each interview as a token of gratitude. Each interview lasted approximately 1 hour. Interviews were conducted via private Facebook and Facetime video chat. Active listening skills were used by me to help the participants feel comfortable when discussing their memories and feelings.

A voice recorder was used to record the interviews. The voice recorder was checked and tested prior to each interview to ensure it was in good working order and

picked up the sound of the video chat interview. Field notes were used to capture any nonverbal responses during the interviews. Field notes also served as a reminder to revisit a topic of interest or to clarify an answer later in the interview. At the onset of each interview, I ensured that the participant was comfortable and that he or she was aware of the option to refuse to answer any question or to discontinue the interview at any time. None of the participants refused to answer any of the interview questions, and each participant completed the interview without a break or interruption of any kind.

The semistructured interview protocol allowed for open-ended answers to the questions. Some questions or subquestions were asked out of sequence, depending on the narrative provided by the participants. Some participants were forthcoming with deeper disclosures from the beginning while other participants began to feel more comfortable disclosing deeper elements as the interview progressed. Probes prompted deeper reflection for some of the participants. At the end of each interview, I scheduled follow-up meetings for member checking.

I manually transcribed the recordings verbatim directly following each interview and saved the transcription n a Word document. Each recording was played several times over to ensure the accuracy of transcription. Saturation occurs when no new data arises (Wahlstrom, 2017). Saturation was achieved after 12 interviews and transcriptions when no new data emerged. The data collection procedures remained consistent with the procedures outlined in Chapter 3. No unusual circumstances were encountered in the data collection. The qualitative research component of member checking was enlisted where each participant was provided with a summary of the transcript and a description

of the themes identified within the data. Each participant found the summaries to be an accurate reflection of the interview.

Data Analysis

A generic qualitative study enables the exploration of data by identifying recurring themes that emerge in response to interview questions (Starnino, 2016). The following steps were used to assist in the process of discovering themes:

Step 1: Listening, Reading and Sketching Idea

The initial analysis procedure included listening and relistening to the recordings of each participant's responses as they related to the research questions. Codes were identified that were later clustered into groups of themes. Field notes from the interviews were embedded within the body of the interview text. The process of sketching ideas involved making margin notes in the field notes I took from the interviews.

Step 2: Physical Manipulation of the Text

The next step was to identify significant statements within the transcripts. This step involved physically manipulating the data using a variety of different methods. Statements with similar meaning were identified using different colored highlighted text on the computer. These methods enabled a synthesis of theme clusters with invariant meaning. Transcriptions were also printed out and color-coded with different highlighters.

Step 3: Coding

Coding is a qualitative research technique used to organize data into categories and themes that enable a process of inductive reasoning (Starnino, 2016). For the

purpose of this study, codes were defined as labels that assign symbolic meaning to the descriptive information compiled in a study (Starinino, 2016). I also used the data analysis strategy of counting the frequency of codes and relating categories to build a logical chain of evidence. Coding took place without the use of specialized computer software programs.

Step 4: Identifying Themes

Identifying themes is a process of subsuming particulars into the general (Starnino, 2016). I identified codes and reduced codes to themes. This involved identifying salient themes and patterns or making notes of identified pattern regularities. Groups of word repetitions were listed under different headings. Words that described the participants' initial reaction when told about their partner's mental health status such as "it explained a lot" and "not surprised" were examples of phrase repetitions with a similar theme. Lists of comparative and contrasting codes were compiled, and headings were created that represented the emerging themes. Several metaphors emerged across the data. For example, Participant 1 referred to the woman he dated with bipolar disorder as "the Rolls Royce with the dent in it because she was absolutely amazing other than that one fact which was pretty large." This quote provided a rich and complex description of a bitter sweet memory of the woman he dated, embellishing both her qualities and shortcomings. As codes and clusters of codes were observed, several overarching themes began to surface.

Data Analysis Findings

After listening and relistening to the recordings of each of the participant's responses and transcribing the interviews, I began to identify codes. The codes that I identified were then clustered into groups of themes. I identified significant statements within the transcripts to produce the emergent themes and subthemes. The themes are broken down in Table 2.

Table 2.

Themes

Themes	Subthemes
Sense of Relief	
Sense of Fear	Fear of public displays, Fear of being uninformed, fear of stigma and stereotypes, Fear of irrational behaviors, Fear of unbalanced relationship, Fear of becoming a caregiver, Fear of triggering
Unmodified Affection	
Benefits of the relationship	Improved sex life
Resolution of unfair situations	Resolve through silence, resolve through exiting the situation
Reluctance to date an individual diagnosed with bipolar disorder again	Reluctance due to infidelity

Evidence of Trustworthiness

Credibility was established by following rigorous procedures for the data collection and data analysis. Codes and themes were not predetermined, but identified throughout the process of listening to the recordings, reading, and rereading each transcript. As each case was analyzed and coded, it became apparent that experiences, feelings, and thoughts fit into categories that would be well represented by the same themes. Member checking consisted of presenting each participant with a summary of

his or her transcript with a description of the major emergent themes. Participants were asked if the summary was an accurate account of the interview and if the themes provided an accurate interpretation of their responses. All of the participants stated that the summary and the list of themes provided an accurate interpretation of their interviews.

Rich and thick descriptions were used throughout the research process in an attempt to accurately and clearly convey the participants' lived experiences and thus ensure transferability. Direct quotations from each transcript were used where possible. Dependability was established by maintaining an audit trail that included 12 recorded interviews, 12 transcriptions, 12 files of codes and emergent themes, the interview guide, 12 summaries to be used for member checking, and one contact sheet. Confirmability was established by reflecting on the role of the researcher throughout the entire study.

Results

Sense of Relief

The theme sense of relief emerged from the data. When suspicions about a bipolar diagnosis were confirmed, a sense of relief arose with the revelation of their partners' diagnosis. Participant 1 expressed his sense of relief when he stated, "I would say it was more of a relief than anything because now I knew sort of what I was dealing with and didn't have to play the guessing game anymore. Then you know could go forth from there." Participant 3 stated, "it really explained some things." Participant 9 said that she "understood him better." Their partner's diagnosis disclosure explained some behaviors the respondents found peculiar.

Sense of Fear

A theme that emerged from the data was that most participants had a sense of fear when confronted by the disease in a loved one. The majority of the participants stated that this was the first time they had been faced with bipolar disorder in a loved one, and they were terrified because they did not know how to respond. Participants were shocked, scared, and even "mortified" (Participant 12) by their partner's mental health status disclosure. Among those who were shocked and scared, the news of their partners' bipolar diagnosis was mostly accompanied by perceptions that they had a lack of knowledge about the disorder. Participant 6 stated, "initially I was confused because I did not understand exactly what it was." Similarly, Participant 2 also stated that he "didn't really know anyone who suffered from mental illness." A subtheme of a sense of fear that emerged was a fear of public displays. Participants discussed how they were afraid that their diagnosed partner would act out in front of family and friends as well as strangers without warning. Another subtheme derived was that respondents felt this fear because they were uninformed about the disease. Several of the participants stated that they had never known anyone with bipolar disorder, and they were challenged to do research on the subject out of fear of being uninformed. Stigma and stereotypes associated with the disease also caused participants to fear what society would say about the relationship of interest, which led to a subtheme of a sense of fear: fear of stigma and stereotypes. Participants were fearful that their relationship would be perceived negatively by society. Respondents also felt a sense of fear because they did not know if they should accommodate irrational behaviors or try to correct them. Respondents had a

fear of triggering their partners' symptoms at any given time. Furthermore, respondents felt a sense of fear that their partner would need them at inconvenient times. Respondents asserted that the relationship was unbalanced with most of the responsibility falling on them as the healthy partner, which circles back to equity theory. A majority of the participants described a situation where their diagnosed partner relied on them for help or safety at a time when it jeopardized the participants' own opportunities or wellbeing, and this was a challenge. This emerged as a subtheme of a fear of becoming a caregiver if the relationship progressed. Participants asserted that there were signs of dependency even at early stages of the relationship. This subtheme is also related to equity theory. Equity theory asserts that the balance of give and take in a relationship is disrupted when the diagnosed partner requires more from their partner (Yum & Canary, 2009). As it relates to the research question, participants had a sense of fear due to several dynamics of the relationship and at both the acquisition phase or early stages of the relationship and in the later stages while the relationship was being maintained.

Unmodified Affection

Since 9 of the 12 participants stated that the revelation of their partner's mental health status did not negatively affect their feelings, the theme of unmodified affection and stability emerged. Seven of the twelve participants stated that their feelings for their partner did not change. Participant 1 who suspected his partner was bipolar stated that when he found out "my heart was set to help her rather than turn my back". Two participants' feelings changed, but in a positive way. Participant 10 was "relieved" and optimistic", while participant 11 became more "empathetic". Although none of the

participants are currently involved with the diagnosed partner, a majority of the participants ended the relationship either on mutual terms or due to reasons unrelated to the bipolar diagnosis such as infidelity or distance. Respondents expressed that they wanted to stick around and help their partner and that initially their partner's diagnosis did not change their sense of commitment. As it related to the research question, the participants experienced unmodified affection at the acquisition phase of the relationship that provided the basis for relationship maintenance with their partner who has been diagnosed with bipolar disorder.

Benefits of the Relationship

Another theme that emerged was one of benefits. Nine of the participants asserted that they enjoyed their partners' emotional highs. Seven of the participants suggested that their partner's bipolar disorder added to the excitement of the relationship and elements such as great sex life. These participants felt joy when their partner was happy and experiencing emotional highs because when their partners was happy, they were "really happy and energetic" as participant 10 stated. Participant 12 stated he enjoyed the "dangerous element" his partner added to the relationship. Six of the participants stated that they enjoyed the sexual relationship they had with their partner. The remaining participants described their diagnosed partner using words such as "carefree, spontaneous, and exciting". Participants told me that they had a lot in common with their diagnosed partner in terms of music and education and that they enjoyed the "conversation" and "social vibe" as stated by participant 1. Participant 1 said "at the time I thought that her being bipolar added to her freakiness in sex. Like you know she was a

little out there which I enjoyed, but I had no complaints about that." These benefits the participants garnered from their diagnosed partner contributed to the longevity of some of the relationships. In relation to equity theory, the benefits helped to balance the relationships so that the healthy partner benefited from the relationship as well.

Resolution of Unfair Situations

Another theme that emerged from the interviews was the resolution of unfair situations. Most of the participants had an experience where they felt that both parties were not being considered. Five of the twelve participants stated that they resolved the unfairness and challenges of the relationship by breaking up or divorcing. Only 2 participants, participant 9 and 12, tried to talk to their partner and connect them with resources. For two of the participants, participants 5 and 7, the issues went unresolved or are still being resolved through custody battles. The remaining participants resolved unfair situations with silence and space. Resolution of unfair situations was broken down into two sub themes. One sub theme was the resolution by exiting the situation and the other subthemes was the resolution through silence or being non-confrontational. The group of participants were split on which method of resolution they utilized, with some of the issues of unfairness still unresolved in the present, such as with custody battles. Participant 2 stated that "words only added fuel to the fire". Participant 2 stated that "silence was my only salvation". Participant 1 who also decided to avoid confrontation described how he found resolution by saying I'm "letting you do your thing, just call me when you want to talk". Methods of resolution aided in prolonging the relationship, or were experienced by participants at the maintenance stage of the relationship.

Reluctance to Participate in a Relationship with an Individual Diagnosed with Bipolar Disorder Again

The participants expressed how much they learned about bipolar disorder and what they concluded from their relationships with an individual diagnosed with bipolar disorder. A theme that emerged was a reluctance to be in a relationship with a bipolar individual again. Four of the 12 respondents, participant 1, 2, 3, and 7 asserted that their partner's mood swings were a challenge during the early stages of the relationship. Two participants expressed their frustrations with their partner crying or getting upset "out of nowhere" (participant 10). Other challenges the participants had were related to understanding their partner's diagnosis and bipolar disorder in general. Participant 2 said his partner's "unpredictability" was challenging in the early stages of the relationship. Other participants, such as participant 8 mentioned mania and "jealousy" as challenges to the relationship. Half of the participants expressed reluctance to be in another relationship with an individual diagnosed with bipolar disorder due to the challenges presented in their relationships. Although half of the participants believe individuals diagnosed with bipolar disorder are deserving of a relationship and ended the relationship on mutual terms, there were several participants who ended the relationship due to infidelity which is a symptom of bipolar disorder related to hyper sexuality.

Summary

This chapter provided an account of a generic qualitative study analysis aimed at providing an understanding of the experiences of African American adults who have dated or been in a relationship with an individual diagnosed with bipolar disorder. The

primary research question that was used was as follows:

How do African American adults experience relationship acquisition and maintenance with a partner who has been diagnosed with bipolar disorder?

The participants associated acquisition, or the early stages of the relationship with fear and challenges, particularly if they were unaware of the diagnosis in the beginning and couldn't explain certain behaviors. They recalled feelings of relief when they found out about their partner's diagnosis. However, nine of the participants expressed that they had difficulty maintaining the relationship with a bipolar partner. Participants did not feel they could resolve issues with their diagnosed partner without triggering symptoms and participants eventually exited the relationship.

In Chapter 5, the findings from this study were related to the current body of literature and in the context of the conceptual framework. The limitations of the study were acknowledged, and recommendations for future research were made in addition to the implications for positive social change resulting from this study.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this generic qualitative study was to examine the attitudes and perceptions of African American men and women regarding their experiences of being involved in dating and relationships with individuals who suffer from bipolar disorder. A qualitative methodology was used because it is fruitful in explaining linkages or mechanisms that cause events (Levitt et al., 2017). Qualitative research was employed because quantitative measures often do not fit the problem well and where many interactions can be hard to quantify, observing participants in their struggles and probing the source of the problems help define what needs to be measured (Levitt et al., 2017). For this study, qualitative data helped to uncover the right events to measure (Levitt et al., 2017). I chose a generic qualitative study because they have no allegiance to nor do they conform with traditional qualitative approaches such as ethnography, case studies, grounded theory, or phenomenology. My goals were to focus on the socio-cultural, focus on the sum of experiences of individuals, to derive themes from the experiences of individuals, and focus on the "what: of an experience unlike other approaches (Percy, Kostere, Kostere, 2015).

Chapter 4 included a discussion of how the themes related to the research question and theory. In this chapter, I also discuss how the theoretical framework assisted with findings. I will discuss implications, suggestions for social change, and study strengths and weaknesses. Recommendations for further research are also offered in this chapter.

Interpretation of Findings

Based on the conceptual framework discussed in Chapter 2, related themes emerged from interview responses. Although my focus was African American couples, there was no significant finding that race played an important part (Cutrona, Russel, Burzette, Wesner, & Bryant, 2011 & Perry, 2013). The majority of the participants described a situation where their diagnosed partner relied on them for help or safety at a time when it jeopardized the participants' own opportunities or wellbeing. According to equity theory, in the context of bipolar disorder, relationships may be impacted by the couple's balance of give and take (Yum & Canary, 2009). There may be more of a unidirectional exchange with the healthy partner's contributions to the relationship far exceeding those of the individual diagnosed with a mental illness, such as bipolar disorder (Yum & Canary, 2009). When the ratio of contributions to remuneration for one partner differs from that of the other, the relationship is inequitable, and individuals in unbalanced relationships are more likely to become distressed (Yum & Canary, 2009). Eventually, all of the participants exited the relationship with the bipolar individual. Although the majority of the participants felt a sense of fear in their relationships, there were some outliers who wish they could have done more for their bipolar partner.

Kopeykina et al. (2016) recognized shifts in sexual behavior as an intrinsic part of bipolar disorder**.** Although I found no formal definition of hyper-sexuality revealed through my research, Kopeykina et al. suggested an elevated incidence of risky sexual behaviors in individuals with bipolar disorder during manic episodes in comparison to individuals with other psychiatric disorders. Furthermore, Kopeykina et al. showed that

in a relationship with one bipolar partner, sexual satisfaction levels were decreased, sexual interest levels varied across polarities, sexual dysfunction incidences during depressive episodes increased, and disparate satisfaction in general in relationships with one bipolar individual. The literature pertained to sexual problems that are specific to diseases such as bipolar disorder, hyper-sexuality induced by mania, and effects of mood cycling on romantic relationships (Kopeykina, et al, 2016). However, the majority of the participants suggested that their sex lives were high quality and an element of the relationship they enjoyed with the diagnosed partner and that the bipolar diagnosis enhanced that aspect of the relationship. The subtheme of an improved sex life was discussed under the theme of benefits in Chapter 4. Although the context of a relationship may seem to assert some control over hyper sexuality, it is a troubling and challenging symptom if a person has bipolar disorder in a relationship (Kopeykina et al., 2016). There were several participants who ended the relationship due to infidelity which indicates hypersexual symptoms.

Recommendations for Future Research

An implication for future research could be long term relationship maintenance when one partner has bipolar disorder and the other does not and how equity theory plays a role in these long term relationships (5-10 year marriages). Another suggestion is to conduct a study where the researcher clarifies and narrows down to a specific aspect of "race" and specifically study that aspect with relationship acquisition and maintenance for African American couples. Finally, an implication for future research could be to explore the experiences of how two people with bipolar disorder function together in

couplehood and the constraints of relationships where both partners have the diagnosis (Chaney, 2014).

Limitations

A limitation of the study was researcher bias. My researcher bias was my insider status from formerly having a bipolar disorder diagnosis. I addressed this bias by acknowledging it in the study. Researcher bias is common, because it is normal for humans to be subjective (Gustafsson, 2017). When this happens, the researcher loses his or her perspective as an outsider (Gustafsson, 2017). Another limitation of this study was that classifications were not possible due to studying a small unit. Finally, there was the question of ethics. I faced ethical challenges in all stages of the study, from designing to reporting. These challenges included confidentiality, informed consent, and my potential as a researcher to have an impact on the participants. Measures of the institutional review board and informed consent were in place to mitigate these circumstances.

Implications for Social Change

This study will contribute to a body of existing literature on mental health and relationships. Social change is promoted by this study through the opportunity to learn about and understand about bipolar disorder and the impact of mental illness on relationships. Not only can this study inform other studies and policy, it can inform practice and future research. A policy implication for this study may be to promote more awareness and access to mental health resources for couples where one partner is not diagnosed and uninformed. More knowledge about mental illnesses, such as bipolar disorder, can change the climate of stigma and fear to an atmosphere of understanding.

Conclusion

This study contributed to the field of mental health and promoted an understanding of the impact of mental health on relationships. A generic qualitative study was used to answer the research question. Relationships with a bipolar partner can be difficult to navigate when the healthy partner lacks knowledge of the disease. Early disclosure about a mental illness was preferred among most participants. The majority of the participants felt that the disclosure of the mental illness explained a lot of behaviors they previously witnessed. Equity theory was enlisted as the theoretical framework for this study. Themes that emerged during data analysis aligned with this theory. I found that the diagnosed partner relied on the healthy partner for help or safety at a time when it jeopardized the healthy partner's own opportunities or wellbeing, which can create feelings of resent men in the undiagnosed partner. According to equity theory, in the context of bipolar disorder, there may be more of a unidirectional exchange with the healthy partner's contributions to the relationship far exceeding those of the individual diagnosed with a mental illness such as bipolar disorder (Yum & Canary, 2009). This perceived unfairness in the relationship can lead to distress between the couples. Although some of the participants' relationships were prolonged after the diagnosis revelation and their feelings did not change after the diagnosis was revealed, all of the participants' relationships eventually ended with the diagnosed individual from reasons ranging from the impact of the illness on the relationship to infidelities and mutual decisions. All of the participants were African American; however, only half of the

participants recognized the impact of race on their relationship. This indicated little difference around the issue regarding race.

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Appendix A: Interview Questions

I will use a semi-structured interview guide to ask the following interview questions and potential prompts:

1. How long were you involved with an individual diagnosed with bipolar disorder?
2. How soon into the relationship did your partner disclose they were diagnosed with bipolar disorder?
3. When would you have preferred to be told that your partner was diagnosed with bipolar disorder?
4. What was your initial reaction when they told you about their mental health status?
5. How did your feelings change when your partner disclosed their mental health status?
6. What made you decide to continue (or end) the relationship?
7. What regrets do you have about that decision?
8. What were the elements of the relationship that you enjoyed?
9. How do you feel your partner having bipolar disorder enhanced those elements?
10. What were some of the challenges in the early stages of the relationship with dating an individual with bipolar disorder?
11. Describe any situations where you felt the relationship was unfair or you felt that both parties were not being considered when dating an individual with bipolar disorder?
12. How did you resolve this situation?

13. What, if any role, do you feel that race played in your relationship?
14. Is there anything else you would like to add regarding your relationships with an individual experiencing bipolar disorder?

Appendix B: Demographic Questionnaire

1. What is your age?
2. What is your marital status?
3. What is your current relationship status?
4. What is your racial identification?
5. Are you currently involved with a person diagnosed with bipolar disorder?
6. What was the length of time in the relationship of interest?

Appendix C: Community Letters

Radford University School of Social Work

From: "[redacted]>
To: "casiajonna3874@yahoo.com" <casiajonna3874@yahoo.com>
Sent: Monday, January 22, 2018 4:20 PM
Subject: Recruitment Flyer

Hello Casey-

I received your request to post your recruitment flyer in the School of Social Work. We do limit flyers to our student lounge area as we are having the walls painted in the building hallways. We can also send your flyer via our student listserv.

Please let me know how you would like your flyer posted. Good luck with recruiting!

Diane

Diane M. Hodge, Ph.D., LCSW
Professor and Director
School of Social Work
[redacted]

[redacted]

From: [redacted]
To: Casey Johnson <casiajonna3874@yahoo.com>
Sent: Wednesday, January 17, 2018 1:25 PM
Subject: Re: UPL Inquiry

Casey, we will be happy to send out this request to our group. We hope you have a great response and best of luck to you in your dissertation.

[redacted]

From: "[redacted]
To: Casey Johnson <casiajonna3874@yahoo.com>
Sent: Wednesday, January 17, 2018 4:04 PM
Subject: RE: Casey Johnson- Inquiry

I am happy to post. Do participants need to be present or are phone interviews possible?

[redacted]
Director of Alumni Relations for Diversity and Inclusion
[redacted]

Appendix D: Recruitment Flyer

Seeking Participants for Walden University Doctoral Study (Dissertation).

Experiences of African Americans Dating Individuals Diagnosed with Bipolar Disorder

A doctoral candidate in the field of Human Services at Walden University is seeking participants to contribute to knowledge through an interview on the subject of African American adults' dating and relationship experiences with individuals diagnosed with bipolar disorder.

I would like to hear from you by August 1st 2018 if you meet all of the following criteria:

- You are an African American Adult
- You are ages 18-45
- You have dated or been in a relationship with someone diagnosed with bipolar disorder
- You have no diagnosis of a mental illness

For more information on the project, including how to participate, please contact Casey Johnson, Walden University doctoral candidate. All inquiries will be treated privately and confidentially.

Phone: [redacted] (Text or Call)

Email: Casey.Johnson2@Waldenu.edu